Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 28001

			For State Of Maryland State Registrar		tificate of L		ientai riyt F	2007	28001
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath Day Year	3. Time of Death
2	/Medic	al	Dines P. Dideriksen 4a. Facility plane (If ngt institution, give street and nymber)		4b. City, Town, or	Location of Death	August	15 200 4c. County of De	7 7000
1	Examin	er	St. AGNES HOSPI	TAL	Bala	HMORE	5	N/A	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. le 218−12−0874 7. Age (In yrs. le 89	ast birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 9/9/191	h 9. Bi V, Year) Dei	irthplace (State or Foreign Country) nmark
	/land ow at		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Loca	ation				10d. Inside City Limits
	e Mary ta-fsh tifled	ctor	MD Baltimore Cat	tonsvil	.le				1 □Yes 2X No
	vith th	Dire	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	Country?
	ns 23a must	Funeral Director	422 S. Rolling Rd. 11. Marital Status 12. Was Deceden Ever in U.S.	3. 13. W	21228 /as Decedent of Hi	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Arr	nerican Indian,
2-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 □ Never Married 2 □ Married 1 □ Never Married 2 □ No WW □ 1 □ Yes, Give Year or Dates:		Yes, specify Cuba	Specify:	Rican, etc.)	Black, Wh Specify: W	
2	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa aind of work done of ONOT use retired	during most of work	ing	16b. Kind of Busines	s/Industry
7 7	l withir jiene. r than the Me	фшо	Elementary/Secondary (0-12) College (1-4or 5+)	Machin		"		Scandia Ma	anufacturing
aua 1	al Hyg	Bec	17. Father's Name (First, Middle, Last)					Maiden Surname)	
yla	should trud Ment	ဥ	Hans Dideriksen	105 14-00-	- Address (Ctrost	Anna Di		or City or Town State	Zin Codol
<u>a</u>	and 2 sho ealth and n 27 is ma ier trauma		19a. Informant's Name/Relationship (Type. Print) Janet Smith / daughter		6. Rollin		atonsvi.	er, City or Town, State	1228
Ġ,	ss 1 ar	0 3	20a. Method of Disposition 20b. Pl		sition (Name of natory or other place		Date	20c. Location - City	
E	it. Pages intment of l intant: If Ite injury or o		4 Donation 5 Other (Specify)	udon Pa	ark Cem-	8/20	/2007	Baltimore	
Бантто	permit Depart Import any Inj once.		21. Signature of Funeral Service Licensee MO142					icott City	mily FH Inc., MD 21043
			23a. Pad. Enter the disease, or complications that caused the death shick, or heart failure. List only one cause on each line.				or respiratory a	rrest,	Approximate Interval Between Onset and Death
2	Physician /Medical	20.0	Immediate Cause (Final disease or condition resulting in death) a. Gastroin Due to (or as a consequence)		d blee	d			
	Examiner			ondo ory.					
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	ience of):					
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58/6U,	rificate be executed g physician and as the burial-transit	edical	d						
	certifica ding ph		IF FEMALE: 23c. If yes, outcome pf pregna	ncv				00d D-to-et-	deliver
.C. BOX	w requires that the death cer been signed by the attendin should be detached for use	ysician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	I death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of o	Day Year
7	requires that the een signed by the rould be detache	ed by Phys	Part II. Other significant conditions contributing to death but not resu Clostridium D.f. al	Col. +		en in Part I.			e to the cause of death? Probably 4 1249 nknown
Hecords,	2 2 2	Completed	Chronic obstructive Pu		-	reose	24a. Was auto perfo 1∐ Yes		
VItal	iyslclan: The lis certificate hε director, page	Be C	25. Was case referred to medical examiner?			26. Place of Dear			
0	Physician: r this certific ral director,	မ	1 Yes 2 No Hospital: 1 Inpatient 2 1 Inpatient 2	ER/Outpatient 28b. Time of		4 Livuising n		dence 6 Other (S	pecify)
0	Attending r death. ector: After by the funer	ation	→ Matural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury	Wor	k? Yes 2 □ No	250. 200020	,.,,,	
DIVISION	ne Hospital or Attendi n 24 hours after death. ne Funeral Director: A bletely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director. After this completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	7	29c. Licens	se number		29d. Date signed (Me	onth, Day, Year)
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54) <i>@</i>		30. Name and address of person who completed cause of death (Item Michelle Hengjeler, mo	23a) (Type, F	rint) Un Arei	nue, B.	Homas	re MO	
	Sta Registi		31. Date filed (Month, Day, Year) AUG. 1 7 2007 32. Restrar's Signa	ture	balls				

State of Maryland / Department of Health and Mental Hygiene

28002 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) TS AUGUST **Physician** ARTHUR L **EMBREY** Ž607 8:32 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK B. Date of Birth

June 24, 1941 Washington DC Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 → M 2 → F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 66 223-50-7550 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any linjury or other traumatic event, the Medical Examinar more. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Frederick Walkersville 1 X Yes 2 □ No |Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 313 Fallsworth Place 21793 United States Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Specify: White 1 ∐ Yes 2. No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Salesman Electric Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur S. Embrey Jeanette Bjorndal 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Harriet Embrey (spouse) 313 Fallsworth Place Walkersville, MD 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State Stauffer Crematory August19,2007 Frederick, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1621 Opossumtown Pike Frederick, Maryland 21702 Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) NEUMONIA IWEE **Physician** /Medical Due to (or as a consequence of): CELL LUNG CANCER **Examiner** -SMALL NON Seque illary list or differs if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 94 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performe 2**X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a:
To the Funeral Completely filled in 156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1612007 C30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rasu Florin 400 W. 7th Street Frederick, Maryland 21701 31. Date filed (Month, Day, Year) State AUG 2 0 2007 Registrar

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JoJean Lorraine Eyler-Hull	State of Maryland / Department of Health and Mental Hygie
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2007 28003

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JOJEAN LORRAINE EYLER—HULL 4s. City, Town, or Location of Death Boonsboro 4c. County of Dea	IntryMARYLAND 10d. Inside City Limits 1 X Yes 2 No try? A. can Indian, Black, TTE Industry Zip Code) AND 21713 Town, State MARYLAND Pike
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RICHARD HULL/SPOUSE 20a. Method of Disposition 1	MARYLAND Pike
Physician Medical xaminer 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate couse. Enter the disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	MARYLAND Pike
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failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. First Unserting Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	Approximate Interval
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. End through a Cause (Disease or injury that initiated events resulting in death) Last events resulting in death) Last b. Due to (or as a consequence of):	Between Onset and Death
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2 23b. Was decedent pregnant in the past 12 months? Compared to this past 12 months December 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 1 Live birth 1	Day Year
20. Was decedent pregnant in the past 12 months? 1	
On the state of th	
The state of the s	
1 Yes 2 ✓ No 3 Pr	bably 4 Unknown
24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No 2 N	utopsy findings available
24a. Was an autopsy prior to performed?	completion of cause of
1 ✓ Yes 2 No 1 ✓ Y	es 2 No
25. Was case referred to medical 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: The contract of Death (Check only one) 26. Place of Death (Check only one)	
The state of the	er: Scene
The state of the s	
28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 22c. Injury at Work? 28d. Describe now injury occurred	
Lo in it is a local series of the series of	
2 Accident Investigation Street and Number or F State St	ural Route Number, City
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 1 Yes 2 No 3 Proposed of Death (Check only one) 24a. Was an autopsy performed? 1 Yes 2 No 2 No 2 Proposed in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 1 Yes 2 No 3 Proposed in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 1 Yes 2 No 3 Proposed in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 1 Yes 2 No 3 Proposed in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 24a. Was an autopsy performed? 1 Yes 2 No 0 Therefore prior to death? 1 Yes 2 No 0 Therefore prior to death? 1 Yes 2 No 0 Therefore prior to death? 1 Yes 2 No 0 Therefore prior to death? 1 Nursing Home 5 Residence 6 Your Other, Nursing Home 5 Residence 6 Your North, Day, Year) 25. Was case referred to medical examiner? 1 Yes 2 No 0 Therefore prior to death? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 1 Yes 2 No 0 Therefore prior to death? 26. Place of Injury at Work? 27. Manner of Death II. Inpatient 2 ER/Outpatient 3 DOA Other, Nursing Home 5 Residence 6 Your North, Day, Year) 28a. Date of Injury at North? 28b. Time of Injury at Work? 28c. Place of Injury at North, Day, Year) 28c. Place of Injury at North, Day, Year at	boro, MD
Find 8/25/200/ Find 7:00 am 1 and 1	
29d. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as st (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated. 29d. Date signed (N. 29b. Signature and title of certifier 1.	he cause(s)
Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to and manner stated. 2 Sections of the best of my knowledge, death occurred at the time, date and place, and due to and manner stated.	
∑Sp. Signature and title of certifier	
Martine The Ville O.C.M.E. August 26, 200	onth, Day, Year)
30. Name and address of person who completed cause of death (Item 23a)	onth, Day, Year)
D D MD 04004	onth, Day, Year)
120 Description Signature 4	onth, Day, Year)
State 31. Date filed (Month Pay Year) 32. Redistrar's Signature	onth, Day, Year) 7

State of Maryland / Department of Health and Mental Hygiene 28004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 06:12 AM 18 2007 GERMAINE EASTERDAY MTLDRED /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days 1 □ M 2 🛣 F 83 Director 215-74-6003 JUNE 27, 1924 MARYLAND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 N Yes 2 No Director MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 332 NORTH MAIN STREET 21713 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. Specify 3 X Widowed 4 ☐ Divorced WHITE 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 11 HOMEMAKER OWN HOME event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be finance had Mental H JOHN H. JONES IRENE MAE MONGAN and N 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21713 permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is ROBERT E. EASTERDAY/SON 5726 MT. CARMEL CHURCH ROAD, BOONSBORO, MARYLAND Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) . BOONSBORO CEMETERY 8/21/2007 BOONSBORO, MARYLAND 21. Signature of Funeral/Service Licensee 22. Name and Address of Facility 7606 Old National Pike BAST FUNERAL HOME Kelly A. Zimmerman Boonsboro, Maryland complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician; The law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 9 ☐ Unknown s been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1□ Yes 2 TNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiper' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Yes 2 No 1 Inpatient 2 DER/Outpatient Certification: To 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Ha til orchard tenue BL ttessestown, M) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 011/11) 31. Date filed (Month AUG 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mercy Medical

5. Social Security Number 6. Sex Baltimore N/A 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🂢 F 220-28-3633 25, Director 73 1934 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show natural", or items 23a or 28a-f shov dical Ex-miner must be notified at 1 X Yes 2 No Director Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 235 S. Potomac St. 21740 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ 3 ☑ Widowed 4 ☐ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene, Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Health Care Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Daniel C. Sisk Anna Margaret Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Earl M. Faith, Jr. 13217 Independence Road, Clear Spring, MD 21722 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 8/29/2007 Smithsburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a se on each line. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one of Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician metastanc ovarian cancer weeks /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month Day Year signed by the at d be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been si 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an s certificate has b lirector, page 2 s autopsy performed? /es 2 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

10 State

Registrar

Isen, M.D. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 64666 August 25, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANITA TSEN, M.D. 301 St. Paul Place, Bartmore, Maryland

2. Registrar's Signature AUG 3 1 2007

Examiner j physician and Division or Vital Records, P.O. Box 68760, as use P signed by the a page 2 should certificate has Hospital or Attending Physician: this 24 hours after death Funeral Director: filled in by

3altimore, Maryland 21215-0036

3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | \$121 \$190 \$200 \$200 4 Homicide 20823 IN DONG MULGING Diney, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PASPULA PHILIP 20832 18101 OLNEY MD ARUNA PRINCE

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 17 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 15 JAMES GREENE 08 07 0728 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months 1**⊠**M 2□F Director 239-20-5951 82 October 04, 1924 North Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lujury or other traumatic event, the IM dical Examiner must be notified at once. 10d. Inside City Limits 10a State 10c. City, Town or Location 1 Yes 2 □ No Director Maryland Allegany LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26 John's Lane Funeral 21502-U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No if Yes, Give Year or Dates: W W II 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🕱 No Specify Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) transmission specialist automotive service dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Greene Anna Hauck ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-Brenda Atkinson daughter 19100 Cabin Run Road, S.W. Frostburg Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cumberland Crematory August 19, 2007 Cumberland Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OBSTRUCTIVE Purmonary CHRONIC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. nding physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death signed by the ar 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate 215 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Main Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ည 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation ours after death. neral Director: A filled in by the fo 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1/Ex Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10A

Name and address of person who completed cause of death (Item 23a) (Type, Print) \mathcal{C} M. D

31. Date filed (Month, Day, Year)

gistrar's Signature 32. AUG 1 5 2007

State

Registrar

42054

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 107 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ROBERT HARRIS SR. 08 10:25 A^M 26 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Dec. 1, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1[XM 2] F Months Year) 1932 214-28-6803 Director WEST VIRGINIA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at MD ALLEGANY FROSTBURG 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be 10229 PINEY MT. ROAD SW 21532 USA Funeral Pages 1 and 2 should be filed within 72 hours after death or Items 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1951 1 Never Married 2 Married 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced 1955 Year or Dates: 'natural' Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HIGHWAY INSPECTOR STATE ROADS Jother 'event, ' 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Be ၉ HARRY H. HARRIS MARGARET HANNA (CRAWFORD) HARRIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S of Health a If item 27 is ALMA JUNE HARRIS SPOUSE 10229 PINEY MT. ROAD SW, FROSTBURG, MD 21532 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department o Important: If any injury or once. 4 Donation 5 Dother (Specify) SILBAUGH CREMATORY AUG. 28,07 UNIONTOWN, PA 22. Name and Address of Facility Hafer Funeral Service, PA 21. Signature of Funeral Sep 1302 National Hwy., LaVale, MD e or complications that aused to a dath. Do not enter the mode of dying, such as cardiac or respiratory arrest, this tonly one cause an ach line. 23a. Part1. Enter the disease shock or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HOZUN, C OBSTRUCTUE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ed by the a detached f 9□Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ WIABETES 1 □ Yes 2 □ No 3 🔀 Crobably 4 □ Unknown Completed Kena WISCASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate ha HYPOTHYRADIS Division or Vital 2 **3**No 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident death 24 hours after death Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 ☐ Homicide filled in Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2

DR. Robert Welik 31. Date filed (Month, Day, Year)

AUG 3 1 2007

29b. Signature and title of certifier

900 SETON Drive Combercaud, NO 21502 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

JGUST 27 2007

State of Maryland / Department of Health and Mental Hygiene 28009 Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** CHARLES LUTHER HALTER 2007 9:15p^M Aug. 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 306 Taney Heights Drive Taneytown Carroll If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F 21212-9380 86 1, Director Oct. 1920 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location show 10a. State 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at Director Maryland Carroll Taneytown 1 XYes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 306 Taney Heights Drive 21787 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1√2 Yes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify:White Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William W. Halter Nettie V. Carl ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rosalie Halter/spouse 306 Taney Heights Dr., Taneytown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Joseph's Cemetery 08/30/2007 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Taneytown, MD 22. Name and Address of Facility Skiles Funeral Home 136 E. Baltimore St., Taneytown, MD 21. Signature of Funeral Service License M00534 21787 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shape, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CONGESTIVE HEART FAILURE **Physician** disease or condition resulting in death) 2 WEEKS /Medical Due to (or as a consequence of): ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine death certificate be executed that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No cate has page 2 s autopsy perform this certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K ONE KINGS DR 21787 WILLIAM R. LINTHICUM M.D TANEYTOWN 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar AUG 3 1 2007 Carlo 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 28010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 18, 2007 7:26P M William Michael Hepler 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Air ar If Under 24 Hrs. s Hours Min. Bel Harford Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days 1**∑** M 2□ F 262-96-3444 60 Jan. 1, 1947 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harford Forest Hill 10g. Citizen of What Country? 10e. Street and Number 730 Walters Mill Rd. 21050 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Commercial <u>Electrician</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julian Baxter Hepler Margaret (unk) Rowan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Frank Hepler / Brother <u>116 Hidden Valley Rd., Covington, VA 24426</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 8-21-07 Towson, Maryland ature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part. Enter the disease, or complications of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause reach line. McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 Immediate Cause (Final disease or condition resulting in death) artino sclerotic Cardio Vascular desease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▼No 24a. Was an ı⊓ yes 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

physician and sthe burial-tran Division or Vital Records, P.O. Box 68760.

Physician

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If Item 27 Is marked other that any Injury or other traumatic event, the 1 once.

Physician /Medical

Examiner

Maryland 21215-0036

Baltimore,

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	Certification:

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death.

To the Funeral Director: A completely filled in by the ft

State

Medical

Registrar

5 Pending investigation

6 Could not be determined

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 ☐ Yes 2 ☐ No

He Rd BEL AIR.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RNARD 1614 CHURCHUI 31. Date filed (Month, Day, Year)

32. Regis ar's Signature AUG 2 2 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007

	•	1 - State Registrar	Cei	rtificate of Death	Reg. N	2001	2001	1
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		WMHS BRADDOCK		CUMBERLAND		ALLEGANY		
Funeral Director		5. Social Security Number 6. Sex 1 9 3 552 1 Usual Residence of Decedent	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth	place (State or Foreignter)	gn
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urs af	by	3/□Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: `	hite	-
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ithin han "	du de	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)		1100	1	
led w hygien her th		17. Father's Name (First, Middle, Last)		18 Mother's Nar	ne (First, Middle, Maid	en Surnama)	2	
an yiailo 6 16. 2 should be filed with and Mental Hygiene. is marked other thar aumatic event, the Menatic event e	Be	77. Patrier's Name (Pilst, Middle, Last)	wford Engli	10. Wolfiel S (Val	· (First, Middle, Wald	l p		
should Me mark	욘	19a, Informant's Name/Relationship (Typ.	1010	ng Address (Street and Number or Ru	ural Route Number, dit	v or Town. State. Zi	p Code)	-
nd 2 sulth ar		Finaval Di	rector ma	Zawler Kemby	12 North	Stownda	16155	52
item othe		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory) or other place)	Date 20c.	Location - City or T	own, State	_
Page Tent of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	al Cem S-1	9-07 M	lenerco	tale Ya	
Darmit. Pages 1 and 2 s Department of Health an Important: If item 27 is of any injury or other trau		21. Signature of Funeral Service License	1 10094	2. Name and Address of Facility	(()	203 No	rth'ST's	
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/Medical Examiner		resulting in death)	Due to (or as a consequence of):	140		1	million	اما
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or At or At offer d Direct in by	Certification:	4 Homicide determined	28e. Place of injury - At home, farm, sti building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Ru ate)	al Route Number,	
pital ours a eral filled		29a. Certifier 1 / Certifying Physi	cian: To the best of my knowledge, deat	th occurred at the time, date and place	e, and due to the cause	e(s) and manner as	stated.	
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifics completely filled in by the funeral director, it	Me	29b. Signature and title of certifier		29c. License number	29d. I	Date signed (Month	, Day, Year)	
10		* Aylen	9-2-	D60478	0,8	3/16/0	7	
20 11		30. Name and address of terson who cor	ppleted cause of death (Item 23a) (Type,	29c. License number DO0478 Print) ENT AUENUE	^	1		
nds	i ly	HAQ HAMAG	111.D. 4235 K	ENT HUENUE, 1	Cumberle	and, ML	1 21502	
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State of Maryland / Department of Health and Mental Hygiene? 6.0.7

			1 - State Registrar	Otate of W	Ce	rtificate of	Death		Reg. No.	28012		
	Physici		1. Decedent's Name (First, Middle, Ruth Smith Hall	Last)				2. Date of De Aug 13 2		3. Time of Death 0525AM M		
	/Medic Examir		4a. Facility Name (If not institution, Calvert Memorial Hos			4b. City, Town, or Location of Death Prince Fredercik 4c. County of Death Calvert						
	Funeral Director			. Sex 7. As	ge (In yrs. last birthday 34 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da		thplace (State or Foreign ountry) sylvania		
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation			-	10d. Inside City Limits		
	e Mary a-f sho iffed a	ctor	Maryland Calvert		Solarans					1 □ Yes 2√ No		
	th with the 23a or 28 ast be not	Funeral Director	10e. Street and Number 11750 Asbury Circle	# 232		10f. Zip Code 20688		10g. Citizen of What Country? United States				
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show nnt, the Medical Examiner must be notified at	d by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of HIf Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Specify:	te, etc. white		
15-0	filed within 72 he Hygiene. other than "natu ent, the Medical	Completed by	15. Decedent's (Specify only highest	grade completed)	(Give	edent's Usual Occup e kind of work done DO NOT use retire	oation during most of work d)	king	s/Industry			
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Maryland	2 should be f and Mental H is marked of raumatic ever	은	Edgar J. Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number						er. City or Town, State.	Zin Code)		
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Baltimore,			20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		20b. Place of Disp cemetery, cre Asbury Cem	osition (Name of ematory or other pla etery Aug 1	ce) !	Date	20c. Location - City o Barstow Mary			
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The same	Physician /Medical Examiner)r	23a. Part1. Enter the disease, or conshook, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to (or as	nter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death			
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			N. Her		H D.		0606	38	8/13/0			
	10		30. Name and address of person w	no completed cause of	death (Item 23a) (Type	Print) 110 - PRINCE	HUSPITI	AL R. DERIC	CAD # U HD	310		
	Sta Registi		31. Date filed (Month, Day, Year)	1 5 2007	ran Signature	Sparke	,					

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			For State Registrar		marylariu /	-	ificate of	Death		Reg. No	2007	
	Physicia /Medic		1. Decedent's Name (First, Middle, Felicie (_{Lasi)} German Hodg	zes				2. Date of De Month August	Da	2007 Year	3. Time of Death 12:40 A M
	Examin		4a. Facility Name (If not institution,	give street and number			4b. City, Town, or Harwoo	r Location of Dea	th	40	County of Death	rundel
	Funeral		Mandrin Hospice 5. Social Security Number		Age (In yrs. last		If Under 1 Year Months Days			rth ay, Year,		place (State or Foreign
	Director		215-16-2276 Usual Residence of Decedent		85	Yrs.			04/14/	1922		yland
tarylan	show ed at	jo l	10a. State 10b. County	1 1	10c. City, To		ation					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
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ath wit	s 23a o nust be	eral D	2013 Gov. Thomas Bla			40.14	21401	line and Original (Cassife Van av N		ted State	
all yiall a filed 12-0000 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Deceder Armed Forces d 1 Tyes 2 If Yes, Give	33	1		lispanic Origin? (an, Mexican, Pue Specify:	rto Rican, etc.)		Black, White,	
hours	tural", af Exar	ed by	3 XWidowed 4 ☐ Divorced 15. Decedent's	Year or Dates		6a. Decede	nt's Usual Occup	pation	-	16b. K	Specify: Whi	
6 1 3 . Ithin 72	ne. nan "na Medic	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4o	r 5+)	(Give k life. Di	ind of work done of O NOT use retired	during most of we d)	orking	Ī		,
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be a	Depar Impor any ir	9 10	21. Signatury of Funeral Service Li	tales.	į. V	- 4			-		ılas Fune gewater,	
- ×			23a. Part1. Enter the disease, or d shock, or heart failure. List o	omplications that caus nly one cause on each	ed the death. D	o not ente	r the mode of dyir	ng, such as cardi	ac or respiratory	arrest,	x >	Approximate Interval Between Onset and Death
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To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (Physician: To the be- xaminer: On the basis and manner	of examination							
To the	within To the comple	Me	29b. Signature and title of certifier	220	<u> </u>		29c. Licens	se number	2 -	/	ate signed (Month	
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State of Maryland / Department of Health and Mental Hygiene 2007 28014 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 26, 2007 **Physician** Janina Johnson 10:15a [™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2312 Titan Terrace Harford Havre de Grace 8. Date of Birth (Month, Day, Year) June 20, 1930 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 XF 77 France Director 423–72–4373 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "neturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo MD Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2312 Titan Terrace 21078 France Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ∐Yes 2 🔯 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify: 2 Specify White 3 Midowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. om 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stefan Michalik Maria Gortchiza 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 I Daniel G. Jandon 2312 Titan Terr. Havre de Grace, MD 21078 (Son) othert altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Furial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department of Important: If any Injury or once. 8/29/07 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Gdns. 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service Licenses Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** WKS /Medical Examiner OSSTAULTIVE PULLINATAY PISITASE 11 YEARS CHAUNIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner cate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 No Division of Vital 1 ☐ Yes 2 No 1 Yes After this certifical funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No ٩ To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 733088 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 BERNHARP BIRNBAM MO 1321 AIVENUOU PKWY SVIRE A SERCAMINA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 3 1 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 23a, Tineb, per PH #25, G870, 8731/07, WS

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 15;547 M **Physician** August Z007 JANNA JOY JORDAHL /Medical 4c. County of Death Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner vista Medical Charle MI lata If Under 24 Hrs. 8, Date of Birth (Month, Day, Year) FEB. 11, 1971 Birthplace (State or Foreign Country) Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 220-11-1642^{1 M 2} Months Hours Days Min Yrs. 36 MD. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside Cify Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐Yes XXNo Director MD. CHARLES NEWBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10340 MT. VICTORIA ROAD 20664 U.S.A. Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 □ Yes 2√2 No Specify. Baltimore, Maryland 21215-0036 Specify: ģ WHITE 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BOYS SCHOOL COUNSELOR other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental H Is marked GILBERT JARAMILLO GAYLA JOY KENSER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once. GILBERT JARAMILLO-FATHER 10340 MT. VICTORIA RD. NEWBURG, MD. 20664 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) M METROPOLITAN CREMATORY 8-11-07 ALEX., VA. 21. Signature of Juneral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Due to (or as a consequence of): **Physician** disease or condition resulting in death) Distress /Medical Examiner Hepatitis Sequentially list conditions Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-trans be exec Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending properties for use as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy certificate 20 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury

Day Year) this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ∠2 □ Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours after To the Funeral Di completely filled in † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) terrino O 30. Name no address of person who completed cause of the (Item 23a) (Type, Print) 102 Centennial Street Suite 102 La Plata, MD 20146 MD Harring

Registrar DHMH 17 Rev 1/2001

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Year)

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** AUGUST 24 2007 0125 1 Benjamin Fleming Johnson, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton memorial Hospito Easton Talbot If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year, **Funeral** 1 M 2 □ F Months Days Hours Director 218-16-6630 November 6, 1924 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygene. Important: if flem 271s marked other than "natural", or items 23a or 28a-f show any Injury or other traummatic event, it is Medical Examiner must be notified at 1 ✓ Yes 2 No Directo Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21629 410 Fountain Avenue United States of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1943 — If Yes, Give 1044 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Completed by Specify: 1944 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 HS Grad Printer Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Mildred Theresa Collier Benjamin Fleming Johnson, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 South Fifth Avenue, Denton, Maryland 21629 Patty Thomason Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/27/2007 Denton, Maryland Denton Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility
Moore Funeral Home, P.A. one South Second Street. Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician days /Medical Due to (or as a consequence of): Examiner rinary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transi and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) Records, P.O. detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Washington 219 Abraham Daniel 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 2 7 3007 Registrar DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 107 28018 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Eva Anna Knox /Medical 2007 10:05A August 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Nursing Home Denton
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Caroline 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Jan 14 9. Birthplace (State or Foreign Country) Delaware 6. Sex **Funeral** 1921 1 ☐ M 2**X** F 86 Months Yrs. Director 220-03-9499 Usual Residence of Decedent the Maryland 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show ury or other traumatic event, tha Madical Examinat must be notified as 10b. County 10c. City, Town or Location 10d. Inside City Limits Delaware 1 ☐ Yes 2 No Director Kent Wyoming 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 162 Willow Tree Circle 19934 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Completed by Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 06 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eli Dill Effie Hurd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Rash/ daughter 162 Willow Tree Cr.; Wyoming, DE 19934 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Mt. Olive Cemetery 08/25/07 Sandtown, Delaware 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA Rec Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. MD 2163 9 Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** d years /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. I 1 Yes 2 No detached 9 Unknown 9 Unknown this certificate has been signed by all director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2E No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 1 Yes 2 No Other: 4 Surrsing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOG 7534 MM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Zaki 920 Market Street Denton, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State Registrar

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29a. Certifier

5 31. Date filed (Month)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

014626

29d. Date signed (Month, Day, Year)

State Registrar

OCME 2006

31. Date filed (Month, Day Ye

32. Registrar's Signature

		For State Registrar		State o	f Ma	ryland	-	irtment d <i>tificate</i>			l Mental Hy	•	2007	20	021
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Marr 3 🛣 Widowed		ied 1 ☐ Yes If Yes, Gi	2 🔯 N ve						eno moan, etc.,				
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To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atten completely filled in by the funeral director, page 2 should be detached for u	Medical C	29a. Certifier (Check only one)	Certifyin	g Physician: To the Examiner: On the b and man	asis of	examination	dge, death and/or inv	occurred at t estigation, in	the time, my opir	, date and pla nion, death oc	ice, and due to the ccurred at the time	cause(s	s) and manner as nd place, and due	stated. to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Vear August 7:40 AM Mary Elizabeth Long 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington County 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F Min. 203-20-9590 79 Director 1927 Pennsylvania Nov 4 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must han actual and Injury or other traumatic event, the Medical Examinar must han actual and injury or other traumatic event, the Medical Examinar must han actual and injury or other traumatic event, the Medical Examinar must han actual and injury or other traumatic event, the Medical Examinar must han actual and injury or other traumatic event, the Medical Examinar must han actual and injury or other traumatic event, the Medical Examinar must have a supplication of the contraction of 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 750 Dual Highway 21740 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ê No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛣 No Specify: Specify: 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Knarr Catherine Dunavan Knarr ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy K. Long - daughter 829 West Franklin St. Hagerstown Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Smithsburg Crematory Smithsburg Maryland 8-21-2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician dio-vascul ero sello 11 days disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has perform certificate 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation Year) (Month, Day n 24 hours after death. ne Funeral Director: Af oletely filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only

JH-1

State

29b. Signature and title of certifier

31. Date filed (Month

Registra

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within 24

30. Name and address of person who completed cause of beath (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

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Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

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Department of H Important: If Iter any Injury or oth

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Funeral

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Baltimore, Maryland 21215-0036

Pages 1 and 2 should be

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To the Funeral Director: After this certifica completely filled in by the funeral director, p

Division or Vital Records, P.O. Box 68760,

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2 ☐ Accident investigation		M 1 ☐ Yes 2 ☐ No		
4 Homicide determined	28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number or City or Town, State)	Rural Route Number,
29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☑ Medical Exam	ysician: To the best of my knowledge, deal niner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place overtigation, in my opinion, death occurred	e, and due to the cause(s) and manner urred at the time, date and place, and o	as stated. due to the cause(s)
29b. Signature and title of certifier	U. Diffort	29c. License number	Aus. 17	, 2007
30. Name and address of person who	completed cause of death (Item 23a) (Type,	Print)	ace Ad Hasers	tanu (1)
	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): d. Due to (or as a consequence of): Due to (or as a consequence of): c. Due to (or as a consequence of): d. D	Due to (or as a consequence of):	disease or condition resulting in death) Sequentially list conditions, last, learning to immediate cause. Enter Underlying that inlated events resulting in death) Last Due to (or as a consequence of): Due to

State Registrar

31. Date filed (Month, Day, Year) AUG 21



DHMH 17 Rev 1/2001

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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Denartment of Health and Mental Hvoliene	Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at	
8,	Phy /M Exa	sicia edic imin	1 2
Division or Vital Records, P.O. Box 68760,	oltal or Attending Physician: The law requires that the death certificate be executed ansafer death.	rral Director. After this certificate has been signed by the attending physician and illed in by the funeral director, page 2 should be detached for use as the burial-transit	

Directo

		1 - State Registrar	Cer	tificate of L	Death	Reg	J. No.	•		, 1
		1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day	Year 3	3. Time of De	eath
Physicia /Medic		LUE B. LEASE, SR.				AUGUST			1:30 A	\mathbf{A}_{\bullet}^{M}
Examin	12	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of	of Death		
		417 VALLEY STREET		CUMBERI			ALLI	EGANY		
Funeral		450M 000 E	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	/ear)	9. Birthplace Country)	e (State or F	oreign
Director		217-30-1304	71 Yrs.			NOV. 8,1	935	WEST	VIRGI	NIA
×		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d.	Inside City L	Limits
sho	ō	MD ALLEGANY	CUMBERLA	AND					1 Yes 2	□No
28a-	Director	10e. Street and Number	COI IDENTIA	10f. Zip Code		100	g. Citizen of W	hat Country	?	
a or		417 VALLEY STREET		21502						
ns 23 mus	Funeral	11. Marital Status 12. Was Decedent	Ever in U.S. 13, V	Vas Decedent of His	spanic Origin? (Sp	ecify Yes or No-	U.S.A. 14. Race	- American	Indian,	
r iter	Fur	Armed Forces:	No I	f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black	, White, etc.		
ai", o Exan	by	3 ☐ Widowed 4 ☐ Divorced If Tes, Give Year or Dates:	54-157	1 ☐ Yes 2 X ☐ No	Specify:		Specify:	WHITE	${\mathfrak T}$	
natur	Completed	15. Decedent's Education (Specify only highest grade completed)		lent's Usual Occupa kind of work done d			6b. Kind of Bus	iness/Indus	try	
an "l	ng	Elementary/Secondary (0-12) College (1-4or	5+) life. L	OO NOT use retired,)	9	163 T1 W			
ygier ner th t, the	Co		SUF	PERVISOR		·	MAINTE			
d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Ma	aiden Surname	")		
Mer	은	LUE THOMAS LEASE	1			MAE LEAS				
h and ris n		19a. Informant's Name/Relationship (Type. Print)	_	ig Address (<i>Street a</i>	and Number or Rui	ral Houte Number,	City or Town, S	itate, Zip Co	ide)	
Healt em 2 ther		LYNDA HALLER LEASE / WIF 20a. Method of Disposition	E 417	VALLEY S			D, MD Oc. Location - 0	21502		
or or or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cren	natorý o <u>r</u> other place	e)	-				
rtmer rtant:		4 □ Donation 5 □ Other (Specify)	CUMBERLAN			3/2007	CUMBER	L'AND,	MD	
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	(A)	Name and Addres UPCHURCH	FUNERAL	HOME, P.	Α.			
		23a. Part1. Enter the wease, or complice nons that cause	the death. Do not ent	202 GREEN					502 pproximate	
W.		shock, or heart failure. List only one cause on each li Immediate Cause (Final	ne.		_	or roophatory arrot	,,,	l ln	terval Betweenset and Dea	
nysician Medical		disease or condition resulting in death)		ANCE				12	<u> </u>	<u>></u>
xaminer		Due to (or as	a consequence of):							
	e.		a consequence of):					_		
ansit	min	Cause (Disease or injury								
n and ial-tra	Examiner	that initiated events resulting in death) Last C Due to (or as	a consequence of):							
physician and s the burial-transit		d								
ding phy se as th	edical						71			
endin use	In/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		Ectopic pregnancy			23d. Date	of delivery		
e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Other (specify)			Mor	nth Da	ay Yea	ar
by th	Physician	9 Li Unknown								
gned se de	by F	Part II. Other significant conditions contributing to death b	ut not resulting in the ur	nderlying cause give	en in Part I.	/	icco use contri			
en si ould l		17/3/OKY OF	SICHE	12/7		1 🗗 🗸 es	2 □ No	3 Probabl	ly 4 □Unk	known
as be 2 sh	Completed					24a. Was an autopsy	24b. W	ere autopsy	y findings ava	ailable
ate h	m o					perform	ed?	eath?	⊒ √0	
ertific ctor,	Be (25. Was case referred to medical examiner?				th (Check only one)			
his or	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpati			4 Li Nuising n	ome 5 Resider	ice 6 □Othe	r (Specify)		
Viter t		27. Manner of Death 28a. Date of Injune 1 ☑ Natural 5 ☐ Pending (Month, Date of Injune)		Work		28d. Describe hov	v injury occurre	∌di		
tor: A	cati	2 Accident investigation			Yes 2 □ No					
fter d Direc in by	Certification:	Jatanasia and Zoe, Flace of III	ury - At home, farm, str c. <i>(Sp</i> ec <i>ify)</i>	еет, тастогу, опісе		28f. Location (Stre City or Town,		ir or Hurai H	oute Numbe	31,
eral 6		29a. Certifier 1 Certifying Physician: To the best	of my knowledge, death	h occurred at the tim	ne date and place	and due to the car	rea(e) and mar	nnor ac etat		
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	edical	(Check only one)	f examination and/or in							
omple	Med	29b. Signature and title of certifier		29c. License	number	29	d. Date signed	(Month, Da	y, Year)	
> F ō				NY	ISUN/	NU	08-0	6-21	207	
1/IUA		30: Name and address of person who completed cause of	leath (Item 23a) (Type	Print)		1	11 1	0-		
3,742		This Rhowing	221.50	Matinn	0 /1/11/11/11	hinder	a 1010	JW	1)219	501
Sta	te		ar's Signature	1 /W 11 W/	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Triving L	MI	1 1/		-
Registr		AUG 1 0 2007 Augustus	S. Span							
	_	# -								

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			For State	State o	of Marylar		artment of H		and Me			200	7	28025	
5.			Registrar 1. Decedent's Name (First, Middle, La	st)		061	illicate of L	Dealli		2. Date of De		200	1	3. Time of Death	,
	Physici /Medi		MARGUEF	LITTE			MALONE			Month 08	23 Day	200	ear 7	2004 M	
	Examir		4a. Facility Name (If not institution, given	re street and nu	mber)		4b. City, Town, or	Location o				County of		2004	_
			WMHS-BRADI		IPUS		CUMBERLA					LLEGA	NY		
	Funeral Director		Z17-Z0-00 10	Sex I□M 2□F X	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 4	B. Date of Bir (Month, Da Jun 29	th ay, <i>Year)</i> , 192	8	Birthpl Count	ace (State or Foreign	
	land ow rt		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10	Od. Inside City Limits	_
	Mary I-f sho fied a	tor	WV Minera	al		Fort A	Ashby							1 ☐ Yes x² ☐ No	
	th the or 28g	Director	10e. Street and Number				10f. Zip Code				10g. Citi	zen of Wha	at Count	try?	-
	ath wi	ra	HC 86 Box 31A					26719	9			USA	4		
36	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examiner must be notified at	by Funeral I	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3√☐ Widowed 4 ☐ Divorced	12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gi Year or D	2 ₹□ No ve		Vas Decedent of Hi f Yes, specify Cuba □ Yes 2 No	ispanic Orig an, Mexican Specify:	gin? (Spec n, Puerto R	ify Yes or No ican, etc.)		14. Race - Black, Specify:	White, e	etc.	
5-0036	2 hou atura cal E	led t	15. Decedent's E	ducation	ates.	16a. Deced	ent's Usual Occupa	ation				nd of Busin			
213	within 72 ene. than "nai he Medic	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give life. E	kind of work done o OO NOT use retired,	during most)	t of working	7				,	
7	be filed within 72 hortal Hyglene. d other than "natuevent, the Medical	Sol	12			Educa	tor						<u>o.</u> S	Schools	
and	t be filed intal Hygi ed other event, tl	Be	17. Father's Name (First, Middle, Last)						First, Middle lilleary	, Maiden	Surname)			
>	iges 1 and 2 should be it of Health and Menta If item 27 is marked or or other traumatic ev	은	James Hilleary 19a. Informant's Name/Relationship (Type, Print)		19b Mailin	g Address (Street a				er City o	Town Sto	to Zin	Cadal	_
<u> </u>	and 2 sealth ar		Mark Malone	,,	on		. Box 1	ina reambo	or riureir	Fort			W	7 26719	
e,	es 1 al of Hea Fitem		20a. Method of Disposition	1-		Place of Dispos	sition (Name of natory or other place	e) !	Da	te	20c. Lo	cation - Cit	y or Tov	vn, State	-
aitimor	Page ment ant: II ury o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special				eral Home,		8/2	28/2007	Cre	esapto	own	MD	
Dail	permit. Pages 'Department of H Important: If ite any Injury or ot once.		21. Signature of Funeral Service Lice)see	1001	22	Name and Addres Scarpelli 108 Virgi				nd. MD	21502			
ľ			23a. Part . Enter the disease, or copy shock, or heart failure. List only	plications that o	aused the deat	th. Do not ente								Approximate Interval Between	
	Physician		Im ediate Cause (Final disease or condition		EPSIS									Onset and Death 3 DAYS	
	/Medical Examiner		resulting in death)		or as a conseq	· · · · ·	W.								_
		7	Sequentially list conditions,	D	IVERTICU (or as a conseq		HBSCESS						1	2YAC OI	_
_	uted trnsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	240.0	(0) 40 4 0011000	delice oi).							Ť		
<u></u>	execting and ital-tra	Еха	that initiated events resulting in death) Last	Due to	or as a conseq	uence of):							+		-
0,00,	cate be executed physician and the burial-transit	dical		_d		_									
	ertifica ing ph e as th	Med	IF FEMALE:							_					_
O. DOX	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours affer death. Within 24 hours affer death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1□Live b	come pf pregna birth 2 ☐ Feta lant at time of d own	al death 3 🗌	Ectopic pregnancy Other (specify)				2	3d. Date of Month		y Day Year	
ŗ.	that the ed by detac		Part II. Other significant conditions of	ontributing to de	eath but not res	ulting in the un	derlying cause give	en in Part I.		23e. Did to	obacco us	se contribu	te to the	cause of death?	-
corns,	requires leen sign hould be	Completed by	CORONARY ARTE		EASE						Yes 2] Proba		
ט	has by	mple	AORTIC STENOS	212						24a. Was autop	osy	prio	to com	sy findings available pletion of cause of	
0	n: Th ficate or, pag		END-STAGE &	ENAL D	ISEASE					1□ Yes		deat		2 □ No	
>	rsicla s certi lirecto	o Be	examiner?	Hospital: 1 194	npatient 2□	ER/Outpatient	044			Check only o		Пон			_
5	g Phy er this ieral c	\vdash	27. Manner of Death	28a. Date	of Injury	28b. Time of	28c. Injury Work	4 L Nui:		o 5 ☐ Resid d. Describe I			Specify))	-
2	endin sath. or: Aff he fur	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		th, Day Year)	Injury		.? ∕es 2 □ N	10						
Ž	or Atter de lirecte n by ti	Tific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place buildi	of injury - At ho	ome, farm, stre	et, factory, office		28	f. Location (S City or Tox	Street and	Number o	r Rural	Route Number,	Ī
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	the Hos hin 24 ho the Fund apletely f	Medical	one) 2 Medical Exam	ysiclan: To the niner: On the ba and mann	asis of examina	wiedge, death ition and/or inv		oinion, deat	d place, an	d due to the dat the time,	cause(s) date and	and manne place, and	er as sta due to	ited. the cause(s)	
	Vitl To con	2	29b. Signature and title of certifier	/ 64	D Cost	C	29c. License			-		signed (M			
			Peter U. C				D411	29			AUGU	ST 24	, 2	007	
	10		30. Name and address of person who PETER W. CHO, M.D.	On	CETON	NOUL-	011110=11	AND,	MAIZY	YLAND	21	502			
	Sta Registra	te ar	31. Date filed (North Day Year) AUG 3 1 200	7 July	egistrar's Signa	ture	a a								

DHMH 17 Rev 1/2001

		1	For State Registrar		S	State o	of Mai	ryland	l / Depa Cea	artme <i>tifica</i>	nt of <i>te of</i>	Heal Dea	th and I ath	Mental Hy	gier Reg. N	e20	07	280	026
Ph	ıysiciar		1. Decedent's Name											2. Date of D Month	eath	Day 23	Year	3. Time of	
	Medica	1	FRANCE	S M. M			mbasl			4h Cih	. Town	24 222	tion of Death	Augus		23 tc. County	200°		7 P M
Ε,	kamine	r	Bel Air H					er			7. 10wii, Bel	Air		1			rfor		
Fur	neral	1	5. Social Security Nu		6. Sex	-			st birthday)		er 1 Year	r IfU	nder 24 Hrs.	8. Date of B	irth			place (State ontry)	r Foreign
Dire	ector	-	267–26–716		1 ⊔ M	2[X F	8	5	Yrs.	Tel Cirilla	Days	, ,,,,		1/8/1	922			orida	
land	Ħ	- 1	Usual Residence of D 10a. State	10b. County				10c. City,	Town or Lo	cation								10d. Inside Ci	ty Limits
Mary	ffeed	2	MD	Harfo	ord				Stree	et								1 🗆 Yes	2 X No
ith the	a not	5	10e. Street and Numb							10f. Z	ip Code	01	1.5.4		10g. (Citizen of			
ath w	event, the Madical Examinar must be notified at	8	1347 Mact	on Roa									154			14.5	USZ		
ther de	Icer	5	 Marital Status Never Married 	d 2∏ Marn		Was Deci Armed Fo	orces?		. 13.	Was Deci f Yes, sp	edent of ecify Cul	Hispani ban, Me	c Origin? (Si xican, Puerti	pecify Yes or No Rican, etc.)	0-		ck, White,	can Indian, , etc.	
21215-0036 d within 72 hours aft giene.	Eve	2	3 Widowed 4			1 MYes If Yes, Gi Year or D	ve lates: W	WII		I □ Yes	2 🔯 No	Spe	city:			Specif	y: Wh	nite	
5-0 72 hc	No.	מופח	(Specify	15. Decedent	's Educati	ion ompleted)			16a. Dece	kind of w	rork done	e durina	most of wor	king	16b.	Kind of B	usiness/Ir	ndustry	
121 Within	t. the Madical E		Elementary/Second	dary (0-12)		College (1-4or 5+))	Draft	DO NOT	use retire	ed)		9	Er	ngine	erino	a	
Hygid	event, II		17. Father's Name (F	irst, Middle, L		1						18. N	fother's Nan	ne (First, Middl	1	_			
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.	atic ev	2	Fredric	ck Pood	ck							1	Edna Y	ates					
Maryland id 2 should be file th and Mental Hy	reumatic		19a. Informant's Nan			Print)				_				ral Route Num			State, Zij	o Code)	
	2	\vdash	Derek Manc		Son			20h Pla	134 /			Roao	, Stre	Date MD		154	City or T	own, State	
Baltimore, sermit. Pages 1 a Department of Mes	0 0	1	1 ☐ Burial 2 ☐ 4 ☐ Donation 5	Cremation		oval from	State	Cel	metery, crei	natory or	other pla		W 8/2	4/2007		Leo1a		Own, State	
Baltir permit. P Departme	eny injury or one	-	21. Signature of Fund			0		Eval		. Name a				4/ 2007			, 121		
Ö ESE	ê d		Left	my/		Low	eli	Se						ne, Inc)elta	, PA	17314	1
			23a. Part1. Enter the shock, or heart		complicate	ions that o	caused the	he death.	Do not ent	er the mo	de of dy	ring, suc	h as cardiac	or respiratory	arrest,			Approximat Interval Bet Onset and	ween
Physic /Med			Infimediate Cause (F disease or condition resulting in death)		a		D	epi	essi	9							F	_	eeks
Exam			3 3 3	1		Due to	(or as a	conseque	ence of):										
5		وَ	Sequentially list conditions, leading to imm	ditions, nediate	b	Due to	(or as a	conseque	ence of):										
J. J. B. B.	rial-transit	5	cause. Enter Underh Cause (Disease or in that initiated events		c														
18760, Executed cate be executed physician and	the burial-transit	֡֝֝֝֝֝֝֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	resulting in death) La	151		Due to	(or as a	conseque	ence of):										
68760, ficate be ex	s the bur	200		0.1	d														
Box (death certified attending	use a		IF FEMALE: 23b. Was decedent p	pregnant	23c.	If yes, ou				le						23d. Da	te of deliv	ery	
D. B Geatl he atte	be detached for use as		in the past 12 m	No No		1□Live t 4□Pregr 9□Unkn	nant at tir			Ectopic Other (s						Мо	onth	Day '	Year
P.O.	Jetach		9 ☐ Unknown Part II. Other signific	ant condition	ns coatrib			not result	ting in the u	derhina	Causa a	mon in f	Parti	23e Did	tobacc	O USB COD	ribute to t	the cause of c	leath?
ds,	id be		1	10 F	7/1	6	outil but	1100 1034	ang in the t	derlying	cause g	i v Cii i i i	aiti.			2√2 No		bably 4 🗀	
Record Ine law requir	shou	200			0									24a. Wa	s an	24b.	Were auto	opsy findings	available
The la	page 2 should	5									4			auto per 1 Yes	omed?	,	prior to co death? 1 ∐ Yes	ompletion of c 2□ No	ause of
/ital	Be C	0	25. Was case referre examiner?	ed to medical							1 -		Place of Dea	th (Check only					
Of V	al dire	2	1 ☐ Yes 2 N 27. Manner of Death	lo	Hosp	1 🗆	Inpatient		R/Outpatier	t 3 🗆 C	IOA		Nursing H	ome 5 Res				<i>fy</i>)	
On Significant	funar		1 Natural 2 Accident	5 Pending	9	28a. Date (Mon	th, Day	Year)	Injury	м	28c. Inju Wo 1 [ork?	2 □No	200. Describe	IIOW III	jury occur	160		
Division or Attending after death. Director: Afte	ed in by the funara		3 Suicide	6 Could n	ot be	28e. Place	of Injury	y - At hom (Specify)	ne, farm, str	et, facto	ry, office)		28f. Location City or To	(Street	and Numl	er or Run	al Route Num	ber.
ital or ris after	ni bel															•			
Hosp 24 hour	pletely fil	2	29a. Certifier 1 (Check only 2 one)	Certifying	Physici xaminer	: On the b	asis of e	xaminatio	fedge, deatl on and/or in	occurre restigatio	d at the l	time, da opinion	te and place , death occu	, and due to the rred at the time	cause , date a	(s) and maind place,	anner as s and due t	stated. to the cause(s	s)
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physicien: The law requires that the death certificate hours after deading. To the Funeral Director: After this cartificate has been signed by the attending.	eldmo	- 1	29b. Signature and ti	He of certifier		and man				2	9c. Licen	nse num	ber		29d. [Date signe	d (Month,	Day, Year)	
F 5 F			1 85	MOST	1	N.D	a	r			DZ	565	45		8	124	107		
_	0		30. Name and addres	ss of person v	vho comp	leted caus	se of dea	ith (Item 2	23a) (Type,	Print)	02	- 6	EL	AIR,	MI	5 2	1014	-	B-V
	State		31. Date filed (Month	, Day, Year)		32. F	Registrar'	's Signatu	lie die	à									
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DHMH 17 Rev 1/2001

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Registrar

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2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Branch of Health and Mental Hygiene

			For State Registrar		State 0	n Miai yiai		rtificat		eaith and i Death	,	Reg. No.		00000
	Physici	an	1. Decedent's Name (First								2. Date of Do Month	eath Day	2001	32in80G-28
11	/Medic	al	ELLEN 4a. Facility Name (If not in:	MCDON stitution, give		mber)		4b. City,	Town, or	Location of Deatl	August		County of Death	1:15 P M
	LAdilli		Shady Grove				l		ockvi			M	lontgomer	•
ľ	Funeral Director		5. Social Security Number 117–38–7298		ex □ M 2 🛣 F	7. Age (In yrs. 100	/ast birthday) Yrs.	If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D) Feb. 1	rth av Year) .0, 1	907 9. Birthp Coun Mai	ace (State or Foreign try) ne
	/land ow at		Usual Residence of Deced	County		10c. Ci	ty, Town or Lo	cation				_	1	0d. Inside City Limits
	e Man 3a-f sh tifled	ctor	MD Mor	ntgome	ry	Ga	aithers	burg						1 ∐ Yes 2 X No
	with th a or 24 be no	Funeral Director	10e. Street and Number 9701 Fields	Road	Ant# 24	0.7		10f. Zip		0878		_	izen of What Coun .ted Stat	
	death ms 23	nera	11. Marital Status	Road	12. Was Dece	edent Ever in U	J.S. 13. \	Nas Dece		ispanic Origin? (S in, Mexican, Puer	pecify Yes or N		14. Race - Americ	an Indian,
036	be filed within 72 hours after death with the Maryland ttal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2[3 🌠 Widowed 4 🗆 Di		Armed Fo 1 ☐ Yes If Yes, Giv Year or D	2 ∑ No ve No		it Yes, speci 1 ☐ Yes		n, Mexican, Puerl Specify:	to Rican, etc.)		Specify: Wh	etc. ite
15-0	"natul	letec	15. De (Specify only	ecedent's Ec highest gra	lucation de completed)		16a. Deced	dent's Usua kind of wo	al Occupa	ation during most of wor)	king	16b. Ki	ind of Business/Inc	lustry
212	filed within 72 Hygiene. xther than "na i snt, the Medic .	Completed	Elementary/Secondary (0-12)	College (1	1-4or 5+)		ticia		,		Sh	op Owner	
Maryland 21215-0036	should be filed and Mental Hygis marked other matic event, th	To Be C	17. Father's Name (First, I	Middle, Last)	Pomas M	ilishka				18. Mother's Nar Anna	ne (First, Middle Donkus		Surname)	
	nd 2 should be lith and Mental 27 1s marked c r traumatic ev	ь	19a. Informant's Name/Re Robert A. Mo				1						urg, Md.	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Mentz Important: If Item 27 1s marked any Injury or other traumatic evonce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ O	nation 3 🗆	Removal from	State	Place of Dispo cemetery, cren			e) Aug	ust 18,		ocation - City or To	,
BaltIII	permit. F Departm Importar any inju		21. Signature of Funeral S			/ no	22	. Name an	nd Addres	ss of Facility De	Vol Fur	eral		
F			23a. Part1. Enter the dise shock, or heart failur	ase, or comp	plications that one cause on e	aused the dea	th. Do not ent	er the mod	le of dyin	g, such as cardia	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	=1		monary								Onset and Death Minutes
	/Medical Examiner		resulting in death)			(or as a consec		onous	Thr	ombosis				Days
	7 -	ner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events			(or as a consec		enous) TIIL	Ombosis				раув
-6	tificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		c	(or as a consec	quence of):							
68760,	ate be (nysiciar he buri	edical E		(⊾d									
			IF FEMALE:		23c. If yes, out	tcome of pregn	ancy		_					
O. Box	The law requires that the death certifi ate has been signed by the attending I bage 2 should be detached for use as	Physician/M	23b. Was decedent pregn in the past 12 month: 1 ☐ Yes 2 X No 9 ☐ Unknown		1 ☐ Live b	oirth 2 Fet nant at time of	al death 3 □	Ectopic pr Other (sp					23d. Date of delive Month	ny Day Year
1	w requires that the d been signed by the should be detached	by	Part II. Other significant of	onditions o	ontributing to de	eath but not res	sulting in the ur	nderlying c	ause give	en in Part I.			use contribute to th	e cause of death?
Hecords,	s been shoul	oletec									24a. Was		24b. Were auto	psy findings available
		Completed									auto perf 1∐ Yes	ormed?	death?	npletion of cause of 2□ No
VIta	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to rexaminer?	nedical	Hospital:		7.50/0.4		Othe	26. Place of Dea				
סר	g Physier this	n: To	1 Yes 2 No 27. Manner of Death		28a. Date		ER/Outpatien 28b. Time of Injury		28c. Injury Work	T INGISHING I	lome 5 ☐ Res 28d. Describe		6 □Other (Specify y occurred	/)
SIO	tending Feath. tor; After the funer.	catio	2 Accident	Pending investigation Could not be				М	10,	Yes 2 □ No				
DIVISION	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, it	Certification:	4 ☐ Homicide	d <i>e</i> termin <i>e</i> d	Zoe. Flace	of injury - At h ing, etc. (Speci	ome, farm, str fy)	eet, factory	y, office		28f. Location City or To		d Number or Rura I)	l Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier 1X C (Check only one) 2 ☐ M	ertifying Ph edical Exan	niner: On the b	e best of my knoasis of examin ner stated.	owledge, death ation and/or in	n occurred vestigation	at the tin	ne, date and place pinion, death occ	e, and due to the urred at the time	cause(s) and manner as si d place, and due to	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of	certifier	1			290	c. License	e number			te signed (Month,	
•	-		Ralsi	\	L	M.D.			00(36255	3	Aug	ust 15	2007
	15		30. Name and address of Dr. Patsy Mc						Dri	ve Rock	ville,	MD 2	0850	
	Sta Registr	_	31. Date filed (Month, Day	Year)	2007 32. R	Regionar's Sign	ature	Soul	Ü					

			1 - For State Registrar	State of	Maryland		artment rtificate			nd M	lental Hyg	jiene eg. No.	10	07	2802
	Physic	an	1. Decedent's Name (First, Middle, La								2. Date of Dea Month			Year	3. Time of Death
·	/Medi	cal		Elizabet		LISTE					August	19,	200	7	1:35 A.M.
3	Examir	ner	4a. Facility Name (If not institution, given 303 Summit Avenu		iber)				Location of	t Death			County	f Death 12 t or	
	Funeral		5. Social Security Number 6. S		7. Age (In yrs. la	ist birthday)	If Under		If Under 2		8. Date of Birth	1	15111		ace (State or Foreign
	Director		214-32-4511	1 □ M 2 🔀 F	7	74 Yrs.	Months	Days	Hours	Min.	(Month, Day Jan. 19	Year)	33	Coun	nland
	P 2		Usual Residence of Decedent 10a. State 10b. County		100 City	Town or Lo	antina								
	Aaryla f sho	5	Maryland Washing	ton		gerst								10	Od. Inside City Limits 1 ☑ Yes 2 ☐ No
	28a-	rect	10e. Street and Number			80200	10f. Zip (Code			1	On Citi	zen of W	hat Count	
	3a or		303 Summit Avenu	e				2174	40			- 3	U.S.		,.
	death	Funeral Director	11. Marital Status	12. Was Deced	dent Ever in U.S	13.	Was Decede			in? (Spe	ecify Yes or No- Rican, etc.)		14. Race	- America	
36	or the	Y Fu	1 Never Married 2 Married	1 ☐ Yes	2 ☑ No		1 Yes 2		Specify:	, rueito	rican, etc.)		Specify:	, White, e ພາກ	ite
21215-0036	tiled within 72 hours after death with the Maryland Hygiene. sther then "netural", or tiems 23a or 28a-f show ent, the Macintal Examinar must be notified at	ed by	3 XWidowed 4 Divorced	Year or Da	tes:							10) 10			
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2	be file ital Hy id othe event,	Be	17. Father's Name (First, Middle, Last)					18. Mother	's Name	(First, Middle,	Maiden	Sumame)	
yla	should to the sh	ပ္		. Ocker						He1	en Louis	se P	owne	11	
Maryland	12 should hand 7 to m		19a. Informant's Name/Relationship (l Route Number			715	
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "neturs!", or items 23s or 28s-f show other traumatic event, the Macdical Examiner must be notified as		Quinn Thomas - da 20a. Method of Disposition	augnter	20b. Pla	305_S ace of Dispo	Summit sition (Name	Ave	nue,	Hag	erstown			nd lity or Tox	
JO L	Pages nent of int: If It		1 ⊠Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		Cei	metery, cren .ar Lav	natory`or otl พาา	her place	A	ugus	+ 22			•	Maryland
altimore,	보유 등 등		21. Signature of Funeral Service Lice				emoria . Name and		ark	1	007 L nnich Fu	_		_	Maryranu
ä	Depe Impo any t		Fred L.V.	estal		41	5 Eas	t Wi	lson	Blv	d., Hage	erst	own,	Mar	yland 2174
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca	used the death. ch line.	Do not ent	er the mode	of dying	, such as c	ardiac o	r respiratory arr	est,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	SMAN	Col	Data Pa	7-4-1-1	ATE	× /	116	CARC	م لم.	MA		Onset and Death
	/Medical Examiner		resulting in death)	Due to (o	or as a conseque	ence of):		<i></i>	-		THE CO.	,,,,,	2		,,,,,,,,,,,
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	uted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	240 10 10	r as a conseque	silos otj.									
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8760,	cate be executed physicien and the burial-transit	dlcal	(d											
9	The law requires that the death certificate be executed site has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Med	IF FEMALE:	21											
Box	that the death certific ed by the attending p detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?		th 2 Fetal o	death 3□	Ectopic pre					2	3d. Date	ot delive	ry Day Year
o.	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregna 9□Unknov	nt at time ot dea vn	ath 5□	Other (spe	cify)					1410111	,, ,	Day Tour
٩.	res that t igned by be detac	y Ph	Part II. Other significant conditions	ontributing to dea	th but not result	ting in the ur	nderlying ca	use giver	n in Part I.	·	23e. Did tot	acco u	se contrit	ute to the	e cause of death?
Records,	quires n sigr ald be	Q D	CHRONIC OBSTRUC	TIVE PUL	ronaly	our Dur	59st				10 Ye	s 2[□No :	Proba	ably 4 Unknown
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VIta		BeC	25. Was case reterred to medical examiner?						26. Place	of Death	(Check only on				
5	Physic this co	2	1 ☐ Yes 2 ☑ No		patient 2 E				4 Nur	sing Hor	ne 5 Reside	nce 6	Other	(Specify,)
Division of	Alter Auner	lon	27. Manner of Death 1 Natural 5 Pending	28a. Date of (Month)	Injury , Day Year)	28b. Time ot Injury		c. Injury			28d. Describe ho	w injury	occurre	d	
<u>S</u>	death ctor: , the	Icat	2 Accident investigatio 3 Suicide 6 Could not b		ot Injury - At hon	ne tarm etr	M factory		es 2⊡N		28t. Location (St	root a no	Alumba	e o e Puent	Pouta Numbas
≧	effer Dire	Certification:	4 Homicide determined	building	g, etc. (Specify)	io, tarrii, atre	set, lactory,	Office			City or Town		, ivanioe	OI HUIAI	House Number,
	To the Hospital or Attending Physician: whip 24 hours sider deals To the Funeral Director: Attenthis certific completely filled in by the funeral director.		29a. Certifier 1X Certifying Pt	ysician: To the b	est of my know	ledge, death	occurred a	t the time	, date and	place, a	and due to the ca	ause(s)	and man	ner as sta	ated.
	the Hin 24 the Fu	Medical	(Check only 2 Medical Example)	and manne	or stated.	on and/or inv	estigation, i	n my opi	nion, death	n occurre	ed at the time, d	ate and	place, ar	of eub bi	the cause(s)
	To Too	2	29b. Signature and title of certifier	0			29c.	License	number	٥.	2		, /		Day, Year)
7			Jamb Lot	19				Duc	388	12		81	20/	07	
5	4-4		30. Name and address of person who	completed cause	of death (Item 2	1	and o	SICA	13	U area	IC DX	H	4968	FRST	OWN,
	Sta	te	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signatu	///	10;10	O'CM	COM	1 1/2	0~0	11	0	1179	12
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28030 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Robert Murray MUMMA, Jr. 2007 /Medical AU905+ 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7, Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 X M 2 □ F Director 72 220-28-8058 July 31 1935 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at Directo 1 ☐ Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 17336 West Washington Street 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Machinist Set Up Truck Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Murray Mumma Dorothy E. Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stella Mumma - Wife 17336 W. Washington Street, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 8/22/07 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Fred LIV 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that or or ed the death. Do not enter the mode of dying, such as carriac or respiratory arrest shock, or heart failure. List only one cause on vacciline. Immediate Cause (Final disease or condition resulting in death) **Physician** 0 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 s perform 1□ 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 21 No 1 ☐ Inpatient 3 ☐ DOA P this funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred (Month, Day Year) 1 Natural 21 Accident 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. 81 nature and title of certifier ame and address of person who completed cause of death (Item 23a) (Type, Print) 1 111

State

Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Lage & Amen MA

		1 - State	State	oi iviaryiar	-	artmen ertificat			and N	lental Hy	_		-	2000	
-	-	Registrar 1. Decedent's Name (First, Middle	. Last)			Timean	e or D	caiii		2. Date of D	Reg. No	· ZUU	4	3. Time of Death	L
Physic		Charles	, ,	Clifto	n	Mo	cDona	1 d		Month	Da	y Ye		10:06 A M	
/Medi Examii		4a. Facility Name (If not institution	, give street and n			_	Town, or L		of Death	Hugus		County of E		10:00 A	-
Examin	iei	408 Wempe Dri		,			Cumbe						.ega	nv	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	last birthday	If Under	1 Year	If Under	24 Hrs.	8. Date of Bi	rth	9.	Birthp	lace (State or Foreign	,
Director		234-38-8876	1 M 2 □ F	79	Yrs.	Months	Days	Hours	Min.	(Month, D 11/15			Coun	vy) Virginia	
DE _		Usual Residence of Decedent		140.0											
arylar show d at	_	10a. State 10b. County		10c. C	ty, Town or L	ocation							11	0d. Inside City Limits	
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item item ner r	Funeral Director	11. Marital Status	Armed F		J.S. 13.	If Yes, spec	cify Cuban,	, Mexicar	gin / (Sp i, Puerto	ecify Yes or N Rican, etc.)	0-	Black, V			
irs af	by	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, C	2 🗌 No live Dates:		1 □ Yes	2 ₹ No	Specify:				Specify:	Tai	hite	
2 hou		15. Decedent	's Education		16a. Dece	edent's Usua	al Occupati	ion			16b. F	Kind of Busin			
hin 7 e. an "n Medi	ple	(Specify only highes Elementary/Secondary (0-12)	1	(1-4or 5+)	life.	e kind of wor DO NOT us	rk done du se retired)	iring mos	t of work	ang					
gien gien gien the	Completed	10			Owr	ner an	id Ope	erato	or		L	ivery	Ser	vice	
tal Hy	Be (17. Father's Name (First, Middle,	Last)				1	8. Mothe	r's Nam	e (First, Middle	e, Maidei	n Surname)			
Meni Marked arked	P	Lloyd	Olen		McDon	ald		Lol	a	Vir.	gini	a M	lc Do	nald	
2 short and is m		19a. Informant's Name/Relationsh		_		•	•			al Route Numi		,	-,,	,	
l and Health Im 27 her t		Pansy A. McDon	ald / Wi		408 Place of Disp			ve,		erland Date				1502	_
if of F		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 ☐Removal from	n State	cemetery, cre	ematory or o	ther place)	i				ocation - City			
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee	w						ams Fam , Cumbe				Home, P.A.	
		23a. Part1. Enter the disease, or	complications that	caused the dea								id, MD		1502 Approximate	_
		shock, or heart failure. List	only one cause on	each line.	in, Do not er	iter the mod	e or aying,	, sucii as	cardiac	or respiratory i	arrest,			Interval Between Onset and Death	
Physician /Medical		disease or condition resulting in death)		rescler		ardio	vascu	ılar	Disc	1384			-	l_year	_
Examiner			. Stro	o (or as <i>a</i> conse	quence or):								١.	1 11000	
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xecuted and Il-transit	xaminer	ll ary leading to innectate cause. Enter Underlying Cause (Disease or injury that initiated events	Dive	rticula	r Blee	ding							/	l week	
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ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:				Othor		of Deat	h (Check only	one)_				_
Phys this al dir	T ₀	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 1	Inpatient 2	ER/Outpatie		<u></u>	4 🗆 INU		me 5 X Res 28d. Describe			Specify)	_
ding J. After funer	ion	1 X Natural 5 ☐ Pending	(Mo	nth, Day Year)	Injury	M 2	8c. Injury a Work? 1 □ Ye	es 2∐I		260. Describe	now inju	iry occurred			
death ctor: y the	icat	3 Suicide 6 Could r	ot be 28e Plac	e of injury - At h	ome, farm, st			53 Z		28f. Location	(Street a	nd Number o	r Rura	I Route Number,	_
after Direction of the property of the propert	Certification:	4 ☐ Homicide determi	ned buil	ding, etc. (Spec	fy)	,,	,			City or To			7 71070	rriodie radingel,	
To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buring.		29a. Certifier 1 ☑ Certifyin	g Physician: To th	ne best of my kn	owledge, dea	th occurred	at the time	e, date an	nd place,	and due to the	e cause(s	s) and manne	er as st	ated.	_
e Ho 124 h e Fu	Medical	(Check only 2 Medical I	Examiner: On the	basis of examin nner stated.	ation and/or i	nvestigation	, in my opi	nion, dea	th occur	red at the time	, date ar	nd place, and	due to	the cause(s)	
Within To the Comp	Me	29b. Signature and title of certifier	. \	٨		290	. License r	number			29d. Da	ate signed (N	fonth, i	Day, Year)	
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-//-		30 Name and address of person		/	, , , , ,									.501	_
11/10		Sabahat Nawab,		32 Corp		Drive	, P.O	. Bo	x 26	5, Gra	ntsv	ille,	MD	21536	
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	-	State Registrar			Cei	rtificate of	Death		eg. No.	2007	28	0.3
nysician	_	Decedent's Name (First, Middle, Li						Date of Deat Month	Day	Year	3. Timb-of	Death
Medical		Virginia		_ee		Mille		August		2007	5:45	A
xaminer	4	la. Facility Name (If not institution, gi					or Location of Death	1	4c. Co	ounty of Death		
		10010 Jefferies			14 h :-4h -1 X	Cumbe:	rland I If Under 24 Hrs.	8. Date of Birth		Alle		_
neral ector	1	,	Sex 7. 1 □ M 2 ☑ F	86	last birthday) Yrs.	Months Days		(Month, Day,	, Year)	Coun	lac <i>e (State</i> o <i>try)</i> vland	or r-on
	- 1-	Usual Residence of Decedent		100 0	v. Town or Lo	eation						4 . I I
dat		10a. State 10b. County		100. Cit	y, rown or Lo						0d. Inside Ci 1 ☐ Yes	-
	<u> </u>		Legany	<u> </u>		Cumber	Land					- X
t be n		IOe. Street and Number 10010 Jeffer	ries Road	, NE		10f. Zip Code	21502	1	l0g. Citizer	n of What Coun USA	itry?	
or other traumatic event, the Medical Examiner must be notified at To Be Completed by Finneral Director		11. Marital Status 1 □ Never Married 2 🂢 Married	12. Was Decede Armed Force 1 Yes 2 If Yes, Give	es?		Was Decedent of I If Yes, specify Cub 1 □ Yes 2 🔯 No	Hispanic Origin? (Span, Mexican, Puerl	pecify Yes or No- o Rican, etc.)		Race - Americ Black, White,		
al Exam	20	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Date	es:		dent's Usual Occu				oecify: of Business/Ind	Vhite	
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traumatic event, the Mec	<u> </u>	Oscar	Lee		Rice	9	Ida	Vi	rgini	a c	Johnson	n
anm		19a. Informant's Name/Relationship					t and Number or Ru				,	
er tr	7	Lehew W. Miller	/ Husband				ries Road	· · · · · · · · · · · · · · · · · · ·				50
t to	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□Removal from St	ate 20b. [Place of Dispo cemetery, crer	osition (Name of matory or other pla	ace)	Date	20c. Locat	tion - City or To	own, State	
nuò		4 Donation 5 Dother (Spec			. Hermo	on Cemete	ery 08/0	06/2007	Cum	berland	d, MD	
any Injury or other trau		21. Signature of Funeral Service Lice	ensee				ess of Facility A	dams Fam:			Home,	Р
E 20		Kilent C.	Wourd		1	404 Decat	tur Stree	t, Cumbe	rland	l, MD 2	21502	
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			For State Registrar	State of M	arylallu /		rtificate of			Reg. No	2007	28033
198	Physicia	an	1. Decedent's Name (First, Middle	e, Last)					2. Date of De Month	ath Da		3. Time of Death
	Physicia /Medic		Elsie	Bowen	Maddo	XC			August			5:00 P ^M
	Examin	er	4a. Facility Name (If not institution	n, give street and number)			7	r Location of Dea		40	c. County of Death	
			Calvert County 5. Social Security Number		iter ge (In yrs. last	t hirthday)	Prince I	rederic	S. 8 Date of Bir	th	Calvert	place (State or Foreign
Ġ	Funeral Director		578-38-8303 Usual Residence of Decedent	1 M 2X F	93	Yrs.	Months Days	Hours Mir		ay, Year	r) Coui	ryland
	land ow rt		10a. State 10b. County		10c. City, T	own or Lo	ocation					10d. Inside City Limits
	Mary -f sho ied a	ţō	MD Ca	lvert	H	Iunti	ngtown				}	1 ☐ Yes 2 No
	r 28a noti	Funeral Director	10e. Street and Number	-			10f. Zip Code			10g. C	itizen of What Cou	ntry?
	th with	a	3391 Soper Roa	d			20	0639			U.S.A.	
	ems er mu	ne.	11. Marital Status	12. Was Decedent Armed Forces	?	13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (an, Mexican, Pue	Specify Yes or No erto Rican, etc.))-	 Race - Americal Black, White, 	
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at anone.	by	1 □ Never Married 2 □ Marr 3 ☑ Widowed 4 □ Divorced	If Vac Give	No		1⊡Yes 27∏ No	Specify:				nite
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7	Hygie Hygie ther t	ပ္ပ	12 17. Father's Name (<i>First, Middl</i> e,	Last)			order supe		ame (First, Middle	-		TIT Y
9	d be f	Be C	The state of the s	ard Hatfi	eld			Matti	e E.	Bot	wen	
2	should mark matic	2	19a. Informant's Name/Relations			19b. Maili	ng Address (Street	and Number or I	Rural Route Numb	er, City	or Town, State, Zi	p Code)
2	nd 2 sulth ar 27 is r trau		Jane Maddox Kh		hter	3152	Soper R	oad, Hun	tingtown	, M	D 20639	
a,	s 1 al f Hea item othe		20a. Method of Disposition		20b. Plac	e of Disp	osition (Name of ematory or other pla	ce)	Date	20c. l	Location - City or T	own, State
Ē	Page nent o nt: If		1 N Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		?		Cemetery	1	20-07	Hur	ntingtown	, MD
baltimor	partir porta y Inju		21. Signature of Funeral Service	Licensee			2. Name and Addre		Rausch F	'une:	ral Home	, P.A.
<u> </u>	8 3 E 6 5		William	R. Gros			3325 Mt.				s, MD 20	0736
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that cause t only one cause on each	d the death. line.	Do not er	iter the mode of dyi	ng, such as cardi	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
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T.	requires that een signed by oould be deta	by Pr	Part II. Other significant conditi	ions contributing to death	but not resultii	ng in the	underlyi n g cause gi	ven in Part I.	23e. Did	tobacco	o use contribute to	the cause of death?
coras,	quires en sign uld be								_ 1 🗆	Yes	20 No 3 □ Pro	bably 4 Unknown
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r	e P e	E O							perf 1□ Yes	ormed?	death?	2 □ No
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	or Attending Phys after death. Director: After this in by the funeral dii		27. Manner of Death 1 Natural 5 □ Pendir	28a. Date of In (Month, D		8b. Time Injury	Wo	uryat ork?]Yes 2 ∐No	28d. Describe	how in	jury occurred	
UIVISION	Attending r death. ector: After by the fune	cat	3 Suicide 6 Could	not be 28e. Place of in	njury - At hom	e, farm, s	treet, factory, office		28f. Location	(Street	and Number or Ru	ral Route Number,
2	after after I Dire d in by	Certification:	4 ☐ Homicide determ	building, e	etc. (Specify)				City or To	own, Sta	ate)	
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in the Funeral C	Medical C	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the best I Examiner: On the basis and manners	of examinatio	edge, dea	ath occurred at the transfer of the investigation, in my	time, date and pla opinion, death o	ace, and due to the courred at the time	e cause e, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	Vithin Vithin To th	Me	29b. Signature and title of certifie	er // //	71			se number			Date signed (Month	
l	. •		•	/~/			D 3	33123		Αu	ıgust 16,	2007
	10		30. Name and address of person	who completed cause of	death (Item 2	За) (Туре	, Print)	W24.0	D		miel- M	20670
	Ø		Jonathan Lowe	enthal, M.D.	trap Signatur	Hosp re	ital Rd.,	, #310 , .	rrince F	reae	ELICK, MD	20678
	Sta Regist	ate rar		G 1 6 2007▶	Engua.	· Jr	South	<i>p</i>				

DHMH 17 Rev 1/2001

/Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Division or Vital Records, P.O. Box 68760, ed by the a detached f ate has t certificate

Physician

28a-f show must be notified at

23a or

items

Baltimore, Maryland 21215-0036

director this After

within 24 hours after death

To the Funeral Director:
completely filled in by the?

HDEEB 31. Date filed (Month, Day, State Registrar

Medical

29b. Signature and title of certifier

JABER

4 ☐ Homicide

(Check only

29a. Certifier

100

HOSP ITAL

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 060390

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRINCE FREDERICK RO 20678

32. Registra s Signature Year) AUG 2 0 2007

			For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment rtificate	of H	ealth a Death	and Me		iene2	007	28035
			1. Decedent's Name (First, Middle	, Last)						2	2. Date of Deat	h Day	Year	3. Time of Death
	Physicia /Medic		Mary Theresa	l	McCa	rthy					August		2007	8.51 P M
	Examin		4a. Facility Name (If not institution	, give street and nu	ımber)		4b. City, To	own, or	Location of			4c. Co	unty of Death	
T.	× *		10625 Eastwood		1 =		ilver	Spi	ring	0411 1 -			gomery	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2√CXF	7. Age (In yrs. 92	last birthday) Yrs.	If Under 1 Months	Days	Hours	Min. 711	B. Date of Birth (Month, Day, g 8, 191	Year)	Cou	nplace (State or Foreign untry)
iš.	Director		050-09-6396 Usual Residence of Decedent		92	710.				Au	g o, 191	<u> </u>	N	Y
	iand ow		10a. State 10b. County	****	10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	Mary -f sh fied a	to	MD Montgo	merv		Silver	Sprin	α						1 □Yes 🏋 No
1	r 28a r noti	irec	10e. Street and Number				10f. Zip C	-			1	0g. Citizen	of What Cou	intry?
	n with	a D	10625 Eastwood	Avenue			209	01				US.	A	
	/z nours arter death with the Maryland 'ratural', or Items 23a or 28a-f show dical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Dec	cedent Ever in U	J.S. 13. \	Was Decede	ent of His	spanic Ori	igin? (Speci	fy Yes or No-		Race - Ameri Black, White	
Š į	or it		1 Never Married 2 Marri	ed 1 Tes If Yes, G	2 Mo ive		1 □ Yes X [Specify:		,	j		ite
9500-c	ural"	d by	3 🔀 Widowed 4 ☐ Divorced	Year or I	Dates:	I de Bass	danda Harral	0	Ala a		_			
<u>ဂ်</u>	"nat	Completed	15. Decedent (Specify only highes	's Education it grade completed,)	(Give	dent's Usual kind of work DO NOT use	done d	urina mos	t of working	,	160. KING (of Business/II	ndustry
Z	with ene. than	шc	Elementary/Secondary (0-12)	College 2	(1-4or 5+)	Admini		,		stant		Educa	tion	
ט פ	Hygi Hygi Sther ent, t		17. Father's Name (First, Middle,	Last)							First, Middle, N			
<u>a</u>	ld be lental ked c	To Be	John Henry Hoff	meister				I	lnne	Eliza	beth Br	cogan		
ary	snou and M s mar		19a. Informant's Name/Relations	nip (Type. Print)		19b. Mailin	ng Address (Street a	nd Numb	er or Rural I	Route Number	; City or To	own, State, Zi	ip Code)
Ma	and 2 alth a 127 is ertra	Н	Mary Kathryn Sto	fa /Daug	hter	1119	ennis	Ave	enue.	Silv	er Spri	ina. 1	MD 209	01
ore,	permit. Fages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Fages 1 and 2 should be filed within 72 hours agreement of Health and Mental Highene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	П	20a. Method of Disposition	0 T D f	20b. I	Place of Dispo cemetery crer Ar Lincto	sition (Name	e of	11	Dat			on - City or T	
Saitimor	rag		1 Marial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S _i			Cemetery	n Nat I			n 4, 20	007 2	rlingt	on 172	
<u> </u>	porti		21. Signature of Funeral Service	Licensee		Fr:	Name and	Addres	s of Facili Ilins	ty Funeral	l Home, :	Inc.		
	89 5 8 9	1 1	J. Ken Sula			1					lver Spr		D 20901	
			23a. Ran1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dear each line.	th. Do not ent	er the mode	of dying	g, such as	cardiac or	respiratory arre	est,		Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	a Con	gestive	Heart	Failu	re					2	Onset and Death months
	/Medical Examiner		resulting in death)		(or as a consec									
	S	_	Sequentially list conditions,	D	eroscles		leart	Dise	ease				6	years
	nsit	nine	cause. Enter Underlying Cause (Disease or injury	DU0 10	for se a consec	preside ory								
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c	(or as a consec	quence of):								
00/9	siciar buria	dical E		d										
00	p phys	edic		u										
XO .	attending pl	sician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregn		Je					23d	. Date of deliv	very
ם י	dearr e atte	icia	in the past 12 months? 1 □ Yes 2 ☑ No	4□Preg	birth 2□Feta Inant at time of o		Ectopic preg Other (spec						Month	Day Year
ָ כ	by the	Phys	9 □ Unknown	9□Unkı	nown						T			
ָר .	ine law requires that the deam tte has been signed by the atten page 2 should be detached for u	by F	Part II. Other significant condition	ons contributing to	death but not res	sulting in the ur	nderlying cau	use give	n in Part I		23e. Did tot	oacco use		the cause of death?
ecords,	equir en si ould b										1 🗆 Y e	es 2 N	lo 3 ☐ Pro	bably XXUnknown
3	has be	Completed									24a. Was a		4b. Were aut	topsy findings available ompletion of cause of
	ate h	mo.									perforr	med? 2 I XINo	death? 1 ☐ Yes	2 □ No
VII	ertific ctor,	Be (25. Was case referred to medical examiner?	V				~			Check only on			
5	this o	2	1 ☐ Yes 2 No		Inpatient 2			Othe	r: 4□ Nu		e 5 K Reside			rify)
	Attending Priystclan: r death. ector: After this certifica by the funeral director, p	on:	27. Manner of Death 1 X Natural 5 □ Pending	9	e of Injury nth, Day Year)	28b. Time of Injury		c. Injury Work			d. Describe ho	ow injury o	ccurred	
<u>ה</u>	tend death stor:	icat	2 Accident investig 3 Suicide 6 Could r	ot be	e of injury - At h	ome farm str	M		/es 2□		f Location /Ct	root and N	umbar ar Ru	ral Route Number,
	after of A	Certification:	4 ☐ Homicide determ	ned 200. Flac	ding, etc. (Speci	fy)	cci, lactory,	Office		20	City or Towr		utibet of hu	rai noute ivatribet,
	spira ours neral filled	- 1	29a. Certifier 1X Certifyin	g Physician: To th	e best of mv kno	owledge, death	n occurred at	t the tim	ne, date a	nd place, an	id due to the ca	ause(s) an	d manner as	stated.
	To the registrator Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical one)	Examiner: On the	basis of examina nner stated.	ation and/or in	vestigation, i	in my op	oinion, de	ath occurred	d at the time, d	ate and pla	ace, and due	to the cause(s)
1	within To the comp	Me	29b. Signature and title of certifier		A		29c.	License	number		2	9d. Date s	igned (Month	, Day, Year)
) (il w	En 5 Vole	- 1		17	09748	3		7	mic+ 14	5 2007	
70	e		30. Name and address of person			m 23a) (Type,		∪.) <u>/ 4+</u> C	,		WIL	Jusic It	5, 2007	
<i>ا</i> لا			Or. Alan R. Weinstoo				Silver	Spri	ing, M	ID 20902	2			
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1		Registrar's Sign		la. 10 -							

Christine Maier Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 2007 28036 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day August 18, 2007 0825 hrs Medical Examiner Christine Renee Maier 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 26428 Arcadia Shores Road Easton Talbot If Under 1 Year If Under 24Hrs. 8. Date of Birth/MM/DD/YYYY 9. Birtholace (State or 5. Social Security Number **1671 Funeral** 6 Sex 7. Age (In vrs. last birthday) Months oreign Davs Hours Min Director Country) MD 213-27-1670 M 2 X F 19 Yrs 1987 Usual Residence of Deceden 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1XX Yes 2 No Baltimore MD Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1020 Riverside Avenue 21230 with the Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 X Never Married 2 Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Married 2X No Yes 9 White Divorced Yes, Give Yea Yes 2X No specify: Snecify: tant; If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner ò 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within tent of Health and Mental Hygiene. Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patrick O'Boyle Maier Kathleen Ann O'Bryon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick O'Boyle Maier/Father 1020 Riverside Avenue, Baltimore, MD 21230 20a Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Metropolitan Crematory ment (ug 23, 2007 Alexandria, VA 4 Donation 5 Other Specify. 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Thermal injuries and smoke inhalation Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical per inf g875 1-30 20a-f, perivE,g8/1, 9/11 X UNPENDED ttending physician a Box 68760. IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte I be detached for u 1 Yes 2 No 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of nas performed? death? page certificate | ✓ Yes 2 No 1 V Yes 2 Nο director, 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 DOA this 1 V Yes မှ 28c. Injury at Work? After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural Yes 2 X No Pending

Division of Vital Records, Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director:
completely filled in by the f

To the

State Registrar 2 X Accident

29a. Certifier 1

31. Date filed (Mo

Suicide

Homicide

29b. Signature and title of certifier

Zabiullah Ali, M.D.

AUG 2 7

3

Medical

Registrar's Signat

(Specify) other-residence

8/18/2007

and manner stated

Assistant Medical Examiner

Investigation

Could not be

determined

30. Name and address of person who completed cause of death (Item 23a)

2007



OCME

Subject injured in house fire

or Town, State)

428 Arcadia

28f. Location (Street and Number or Rural Route Number, City

August 19, 2007

Shores Rd. Faston

29d. Date signed (Month, Day, Year)

2:14 am

28e. Place of Injury - At home, farm, street, factory, office building, etc

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene 28037 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8/11/2007 **Physician** Judith Ann Mogor 5:00am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fairfield Nursing Center Crownsville Anne Arundel If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year, 12/4/1951 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 ☐ M 2 🖸 F Country) 55 Yrs Director 171-44-5372 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at MD Anne Arundel Leonardtown Director 1 ☐ Yes 🔏 🖁 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21825 Beem Lane 20650 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "natural", or Ita any injury or other traumetic svent, the Medical Exertine. 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2€ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Milton Harvey Hartzfeld Martha Imogene Giddings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randy Mogor Spouse 21825 Beem Lane Leonardtown, MD 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2000 remation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 8/15/2007 Baltimore, MD Metro Crematory 21. Signature of Funeral Sep vice Licensee 22. Name and Address of FacilityHardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Mumonia disease or condition resulting in death) /Medical Que to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last lea consequence of): Examine certificate be executed burial-transit Due to (or as a consequence of): attending physician Box 68760 ian/Medical as the l IF FEMALE esn. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death Physici 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 No 1 Yes 2 No 1 🗌 Yes To the Hospital or Attanding Physician: : After this certification, funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 vursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident within 24 hours after death To the Funaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of cent 29c. License number 3895\$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sw Glen Burnue MD 21061 208 Crein Mighway AUG 15 2007 31. Date filed (Montt Registrar

			For State Registrar	State of	Marylan	•	artment of		nd Mental Hy			
ı			Registrar 1. Decedent's Name (First, Middle)	e. Last)			incare of	Dealit	2. Date of D	Reg. No.	2007	<u> </u>
	Physicia		Pauline	,,	Ther	esa		Otto	Month	Day		
	/Medic		4a. Facility Name (If not institution	n, give street and num	iber)		4b. City, Town	, or Location of	Death Augu	ST 3,	2007 County of Death	1:00 A
	LXaiiiii		1 Baltimore S	Street. Ap	t. 416		Cum	berland			Allega	iny
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Yea Months Day	ar If Under 24	4 Hrs. 8. Date of B Min. (Month, L	irth Jay, Year)		place (State or Foreign
	Director		217-18-4333	1□M 2∏F	85	Yrs.			10/11			land
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation				1	0d. Inside City Limits
	Maryli f sho ed at	ō		llegany		Cum	berland					1X1Yes 2 No
	the last	Director	10e. Street and Number	.1084113			10f. Zip Code)		10g. Citiz	zen of What Cour	ntry?
	3a or	Ö	1 Baltimore	Street, A	pt 416		, ,	21502			USA	
	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.	S. 13.1	Was Decedent of	f Hispanic Origin	n? (Specify Yes or N Puerto Rican, etc.)	lo-	14. Race - Americ Black, White,	
9	after or ite mine		1 ☐ Never Married 2 ☐ Marr	ried 1 ☐ Yes If Yes, Give	2∏ No		1 □ Yes 2 ☑ N		Tuerto Fricari, etc.)		Specify:	eic.
5-0036	nours ural", I Exa	d by	3 ₩ Widowed 4 Divorced		tes:		71				V	Mhite
7	"nat	Completed	15. Deceden (Specify only highe	t's Education st grade completed)		(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne durina most d	of working	160. Kir	nd of Business/In	dustry
212	withil lene. than he M	d L	Elementary/Secondary (0-12)	College (1-	-4or 5+)		Homem	,			Home	
	e filed within 72 P al Hygiene. I other than "nati vent, the Medica	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's	s Name (First, Middi	e, Maiden	Surname)	
<u>a</u>	Ald be Alental riked o	To B	Joseph	John	Sch	oenade	1	Rose	1		O ' E	Baker
Maryland	2 should be filed within 72 hours after death with the Marylar and Mendal Hygiene is marked tother than "natural", or items 23a or 28a-f show is marked other than "natural", or items 25a or 28a-f show aumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Address (Stre	et and Number	or Rural Route Num	ber, City o	Town, State, Zip	Code)
Σ.	and 2 ealth n 27 I		Irene O. Case	/ Daughte					Morristov	, 	_	
ore O	ges 1 If iter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from S	State 20b. F	Place of Dispo cemetery, crei	sition (Name of matory or other p	elace)	Date	20c. Lo	cation - City or To	own, State
Baltimore,	t. Partmen tant:		4 Donation 5 Other (S		Res				ns 08/06/			Vale, MD
g	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic e once.		21. Signature of Funeral Service	allers	~				adams ra eet, Cumb	-		Home, P.A. 21502
1	1/2(1)		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca	used the deat							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		whatle	Acu		10 andre		lun		Onset and Death
	/Medical		resulting in death)	Due to (c	or as a consequ	uence of):		/	*			
	Examiner	L	Sequentially list conditions,	b								
d	ed isit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Little 40 (c	or as a consequ	uence ot):						
	al-trar	xan	that initiated events resulting in death) Last	C. Due to (or as a conseq	uence of):						
9/8	death certificate be executed e attending physician and of or use as the burial-transit	lical		d								
Õ	rtificat ng phy as th		 									
X R R	death certifica attending ph	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come pf pregna irth 2 □ Feta		Ectopic pregnar	ncy		2	23d. Date of delive	•
	e dea the at ned fo	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregna 9□Unkno	ant at time of d wn	eath 5	Other (specify)				MOUTH	Day Year
ב.	hat the deby detacl		Part II. Other significant condition	ons contributing to de	ath but not resu	ulting in the u	nderlying cause	given in Part I.	23e, Dio	tobacco u	se contribute to t	he cause of death?
ecords,	law requires that the de as been signed by the 2 should be detached	d by		•		3	, ,		1	Yes 2	No 3 Prot	oably 4 □Unknown
ဂ္ဂ	w requ	etec								s an	24h Were auto	ppsy findings available
ě	siclan: The law certificate has t irector, page 2 s	Completed							aut per	opsy forme ¢ 9	prior to co death?	mpletion of cause of
VIta	an: T tifficat or, pe	o C	25. Was case referred to medica	ı				26. Place o	1 Yes of Death (Check only		1 ☐ Yes	2 No
	ding Physician: After this certific funeral director,	.O.	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Ir	npatient 2	ER/Outpatier	nt 3 DOA	ther:	sing Home 5 💢 Re		3 □Other (Specia	fy)
ם כ	ng Ph fter th neral	n: T	27. Manner of Death 1 ♣ Natural 5 ☐ Pendir	28a. Date o	of Injury h, Day Year)	28b. Time o Injury	f 28c. In	jury at /ork?	28d. Describe	how injur	y occurred	
<u> </u>	eath. or: A the fu	atic	2 Accident investi	gation				☐ Yes 2 ☐ No	0			
DIVISION	al or Attendi after death. I Director: A d in by the fi	Certification:	3 Suicide 6 Could 4 Homicide determ	ained Zoe. Flace	of injury - At ho ng, etc. <i>(Specif</i>	ome, farm, str <i>y)</i>	eet, factory, offic	e	28f. Location City or T	(Street and own, State	d Number or Rura)	al Route Number,
_	pital ours a eral I		29a, Certifier 1 🖫 Certifyli	ng Physician: To the	hest of my kno	wledge deat	h occurred at the	time date and	place, and due to th	e cause(s)	and manner as s	tated
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	edical		Examiner: On the ba	sis of examina							
	To the within To the comp	Me	29b. Signature and title of certifie				29c. Lice	ense number		29d. Dat	e signed (Month,	Day, Year)
			· ·	proter			D)	33280			August 3	, 2007
	bool		30. Name and address of person					Cumban	land, MD	2150	>	-
	2 n hs		Sunil K. G		••• 0∠5 egistrar's Signa		Avenue,	cumper.	rand, Pip	2170		
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DHMH 17 Rev 1/2001

			Print in Black In of Maryland / Department			•	•	
		1 - State Registrar		rtificate of	Death	Reg. I		28039
Physici /Medio		Decedent's Name (First, Middle, Last) Myrtle M. Porter				Month L. August	07, 2007 Year	08:00 PM M
Examin Funeral Director	er	4a. Facility Name (If not institution, give street and not	umber) 7. Age (In yrs. last birthday) 93 Yrs.	4b. City, Town, of the lift Under 1 Year Months Days		3. Date of Birth (Month, Day, Yea March 15,	ar) Coui	olace (State or Foreign ntry) ryland
laryland show	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			1	10d. Inside City Limits 1 Yes 2 No
vith the N or 28a-f be notifie	Director	Maryland Allegany 10e. Street and Number 120 South Water	Frostburg r Street	10f. Zip Code			Citizen of What Cou	
Ind 21215-0036 be filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Exeminer must be notified at	d by Funeral	Armed	Give No	21532- Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spec pan, Mexican, Puerto R Specify:		S.A. 14. Race - Americ Black, White, Specify: Wh	etc.
215-0036 thin 72 hours af ne. "natural", or a Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College	(Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of working ed)	16b.	. Kind of Business/In	dustry
ed ala	To Be Com	10 0 17. Father's Name (First, Middle, Last) James Muir	home	emaker	18. Mother's Name (First, Middle, Maid	omemaker len Surname)	
Maryla d 2 should I th and Men 7 is marke	_	19a. Informant's Name/Relationship (Type. Print)			t and Number or Rural			
or Hea		A. Maxene Hetz. d 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from	20b. Place of Dispo	S. Water St. osition (Name of matory or other pla	Da	Frostburg te 20c.	Maryland Location - City or To	21532- own, State
Baltimore, permit, Pages 1 ar Department of Hea Important: If Item: any injury or other		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Frostburg I	Memorial Par 2. Name and Addre		t 10, 2007 F1	ostburg M	aryland
Dep Table 00		23a. Part. Enter the disease, or complications that	ct		eral Home, 57 F		ostburg, MD	21532 Approximate
Physician /Medical cian and cian-iteracy	Examiner	scok, or heart failure. List only one cause or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events cause.	o (or as a consequence of):	L	Discase	toopitatory arrow,		Interval Between Onset and Death
F.O. BOX 68 // hat the death certificate I d by the attending physis	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1□Live	outcome pf pregnancy birth 2 Fetal death 3 gnant at time of death 5 known	⊒Ectopic pregnand □ Other (specify) _ nderlying cause gi		23e. Did tobacc 1 □ Yes	23d. Date of delive Month o use contribute to t 2 No 3 Prol	Day Year
The The page	Completed					24a. Was an autopsy performad 1☐ Yes 2☐	prior to co death?	opsy findings available impletion of cause of
DIVISION Or VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification: To Be	27. Manner of Death 1. Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 27. Manner of Death 5 Pending investigation 6 Could not be determined 28e. Pla bui 29a. Certifier (Check only) 2 Medical Examiner: On the	Inpatient 2 ER/Outpatien e of Injury e of Injury 28b. Time o Injury ce of injury · At home, farm, str dding, etc. (Specify) ne best of my knowledge, deat basis of examination and/or in	f 28c. Inju Wo M 1 Creet, factory, office	iry at rk? Yes 2 No 28 ime, date and place, al opinion, death occurred se number	e 5 Alesidence Bid. Describe how in Bit. Location (Street City or Town, St and due to the cause d at the time, date	and Number or Runale) e(s) and manner as sand place, and due to Date signed (Month,	al Route Number, stated. to the cause(s) Day, Year)
M JJ Sta Registr		30. Name and address of person who completed ca SUNI Gis FA 625 A 31. Date filed (Month, Day, Year) AUG 0 9 2007		Print) Cismber	CLAND.	nd o	2502	2007

			For State Registrar	State	e of Mar	-	epartment <i>Certificate</i>				giene Reg. No. 2	คกร	2804	n
2			Decedent's Name (First, Midd	le, Last)			<u> </u>			2. Date of De Month		Year	3. Time of Death	V
	Physicia /Medic		William J. Powers								gust 08, 2		22:16 P	1
	Examin	er	4a. Facility Name (If not institution	n, give street and	d number)		4b. City, T	own, or Lo	cation of Death			inty of Death	1	
÷.			WMHS - Memorial		7 Ago (In use last hirt	hday) If Under 1		Cumberland f Under 24 Hrs.			egany	mlose (Ctate or Ferri	
	Funeral Director		5. Social Security Number	6. Sex 1 № M 2 □	F	In yrs. last birt			Hours Min.	8. Date of Bin (Month, Da		Cot	place (State or Foreig Intry)	n
	Mar with the		215-14-6124 Usual Residence of Decedent			86				July	14, 1921	Ma	ryland	_
	ylanc now		10a. State 10b. County	1	1	0c. City, Town	or Location						10d. Inside City Limits	
	a-fsk	ctor	Maryland Al	legany		Frostbu	ırg						1 Yes 2 □ No)
	th the or 28 e noi	Director	10e. Street and Number	Mount Plea	asant Stre	eet	10f. Zip (Code			10g. Citizen	of What Cou	intry?	
	23a ust b						215				U.S.A.			
	y within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	11. Marital Status	Arme	Decedent Eve d Forces?	er in U.S.	13. Was Decede If Yes, speci	ent of Hispa fy Cuban, I	anic Origin? (Spe Mexican, Puerto	ecify Yes or No Rican, etc.)	. 14.	Race - Amer Black, White		
36	safte ;ori	by F	1 ☐ Never Married 2 Mar 3 ☐ Widowed 4 ☐ Divorced		res 2 ∏ No s, Give or Dates: W	WIT	1 ☐ Yes 2	No S	Specify:		Spi	ecify:	••	
5-0036	hour	ed		nt's Education	oi Dates. ₩		Decedent's Usual	Occupatio	on		16b. Kind o	Whof Business/I		_
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717	filed within 72 Hygiene. Ither than "nai the Medici	Completed	Elementary/Secondary (0-12)	5	ge (1-4or 5+)	O ₁	ptometrist				owner	operato	r	
٥	be filed tal Hygi d other event, t	Be C	17. Father's Name (First, Middle	, Last)				18	3. Mother's Name	e (First, Middle,	Maiden Sur	rname)		
yland	es 1 and 2 should be filed i of Health and Mental Hygid I them 27 Is marked other r other traumatic event, t	To	Frank Theodore P	owers					Mary Brac	iy				
Marj	2 sho and I Is ma		19a. Informant's Name/Relations	ship (Type. Print))	19b.	Mailing Address (Street and	d Number or Rura	al Route Numb	er, City or To	wn, State, Z	ip Code)	
	1 and 2 Health em 27 I	1 19	Billie E. Powers		wife	1	38 Mount Ple	asant St		Frostbu		aryland	21532-	
aitimore,	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 ■ Burial 2 □ Cremation	3 □Removal f	rom State	20b. Place of cemeter	Disposition (Name y, crematory or off	e of her place)		Date	20c. Locati	on - City or ⁻	Fown, State	
<u>=</u>	. Ра ₍ Imeni tant: Jury (4 Donation 5 Dother (Specify)		Saint M	ichael's Cen			ıst 13, 2007	Frostb	urg M	laryland	
ga	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	Licensee	11217	1	22. Name and		of Facility Home, 57	Frost Ave	Frostbi	iro MD	21532	
K	asa.		23a. P. Enter the disease, of	r complications t	hat caused the	e death. Do n			-			.16, 141D	Approximate Interval Between	
	Physician		mock, or heart failure. Lis	t only one cause	on each line.	INA	W NA	ERI	4 MI	FASE			Onset and Death	
V	/Medical		disease or condition resulting in death)	a. Du	e to (or as a c	consequence of	7 1119	14	7 013	1011012		0	som loge	M
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o n	ath contract	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 🗆 L		Fetal death					23d.	Date of deli Month	very Day Year	
	ne de the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Pregnant at tin Jnknown	ne of death	5 ☐ Other (spe	city)						
7	law requires that the death as been signed by the atten 2 should be detached for u	P	Part II. Other significant condit	ions contributing	to death but r	not resulting in	the underlying car	use given i	in Part I.	23e. Did t	obacco use	contribute to	the cause of death?	_
cords,	uires sign d be	d by	CONGESTI	VE 6	HEAR	5 FA	1 LURGE			1 🗆	Yes 2□N	lo 3□Pro	obably 4 Munknow	n
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ě	sician: The law certificate has b irector, page 2 s	Completed	CARRA	10800	101.	1-1110	V/9Z			auto			ompletion of cause of	
VITAI	in: T ificate or, pa		25. Was case referred to medica	1145	RIYTY	THM	111		C Diago of Doot	1 Yes	2 M No	1 ☐ Yes	2☐ No	_
	Physician: r this certific ral director,	o Be	examiner?	Hospital:	1 ☐ Inpatient	2₩EB/Out	patient 3 DOA	Other	 6. Place of Death 4 □ Nursing Ho 			Other (Spec	ni6.	_
ō	ding Phys h. After this (funeral dir	-	27. Manner of Death	28a. [Date of Injury	28b. T		c. Injury at Work?		28d. Describe			ery)	_
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UNISION	Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	minord 200. F	Place of injury ouilding, etc. (- At home, far	m, street, factory,	office		28f. Location (. City or To		umber or Ru	ral Route Number,	
5	tal or s afte al Dir ed in	Sert	4 El Torriodo	,	Januariy, etc. (opcony)				Ony or You	WII, State)			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical (I Examiner: On t	the basis of ex	xamination and	, death occurred a d/or investigation,							
	ro the vithin 2 ro the complex	Med	29b. Signature and title of certific		manner state	u.	29c.	License nu	umber		29d. Date si	gned (Montl	n, Day, Year)	
1	21) Itc	Man			D	260	907		AUGU	STO	7 2007	
r	5/10#		30. Name and address of persor	who completed	cause of deat	th (Item 23a) (Type, Print)					+	21503	_
سارا	MA	• •	31. Date filed (Month, Day, Year	92	5 B-5.	Signature_	WAISH	KOA	d Cu	mberl	AND	MO	21503	1
ē	Sta Registr	_	AUG 1	2007	1 Page	Signature	Course							

Registrar

6 2007

AUG 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 14, 2007 5:00 P M Gertrude Patterson August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1751 S. Plantation Drive Dunkirk Calvert County If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 💢 F Director 523-64-6979 March 28, 1929 Czechoslovakia Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Director 1 ☐ Yes 2X No MD Calvert County Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1751 S. Plantation Drive 20754 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ White Specify: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Salesperson</u> Retail Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Karl Kieweg Stephani Schelzer ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Lewis (Daughter) 15117 Narrows Lane, Bowie, Maryland 20716 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 17. Resurrection Cemetery Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2007 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funda September 1 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Duncreas Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed burial-trar Due to (or as a consequence of): physician Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year 4□Pregnant at time of death Day 5 Other (specify) ed by the detached signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? Be Completed by 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s has auto perfo certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only on) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 1 Yes Certification: To this Residence 6 Other (Specify) 27. In no of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. D cribe how injury occurred After atural 5 Pending To the Hospins...
Within 24 hours after death.
To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Ccident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Box 68760. P.O. Records,

Division or Vital

State Registrar (Check only one)

29b. Signature and title of certifier

D52830

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9WBBrgakRood #300, Annapolis, MD ZIYU MO 31. Date filed (Month, Day, Year)

and manner stated.

32. Registra Signature 2007▶

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		For State Registrer	State of Marylar	id / Depa <i>Cei</i>	artment of F <i>rtificate of</i>	Health and I <i>Death</i>		gien e U U Reg. No.	7 28043
Physicia		Decedent's Name (First, Middle, La Marie Iona Parro					2. Date of De Month Aug		3. Time of Death
/Medica Examine		4a. Facility Name (If not institution, given Anne Arundel Medium)	e street and number)		4b. City, Town, c	or Location of Death		4c. County o	
uneral rector		5. Social Security Number 212–44–0018 6. S Usual Residence of Decedent	ex	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Sep 30	y, Year)	9. Birthplace (State or Foreig Country) Maryland
28e-f show	tor	10a. State MD 10b. County Anne Art	ındel 10c. Cit	y, Town or Lo	cation				10d. In side City Limits 1 □ Yes 2 🛣 No
23a or 28	al Director	10e. Street and Number 1251 Destiny Cir	cle		10f. Zip Code 2140	19		10g. Citizen of WI USA	nat Country?
o'la	d by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of F f Yes, specify Cubin I ☐ Yes 2X No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Race Black Specify:	- American Indian, White, etc. White
other then "natural", ant, the Medical Ex	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	ducation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Administr	during most of word)	king	16b. Kind of Bus	
marked other than	To Be	17. Father's Name (First, Middle, Last) Lawrence Schmit	Z			Elizab	eth DeVi		
lam 27 is m other traum	1	19a. Informant's Name/Relationship (Marvin Wayne Parro	ott, Sr./Husbar	nd	1251 Des	_	cle, Ann	r, City or Town, S apolis,	tate, Zip Code) Maryland 2140
Important: If itam any Injury or othe <u>once</u> .	-	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation ☑ Other (Specify 21 Signature of Fineral Service Licen	entombment Ceo	dar Hil		ry 200			re, Maryland
a dical miner		23a Ent r the disease, or commock, or h hart failure. List only mediate Cau a (Final disease or condition resulting in Math)	bilications that caused the death one cause on each line. a	n. Do not ente	5 Gov. R	itchie H	y, Seve	rna Park	Funeral Home MD 21146 Approximate Interval Between Onset and Death
the but	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of him that initiated events resulting in death) Last	b. Due to (or as a consequence Due to (or as a consequence d.						
- "	Pnysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetel 4 □ Pregnant at time of de 9 □ Unknown	death 3 -	Ectopic pregnancy Other (specify)			23d. Date Month	
p eq	ò	Part II. Other significant conditions or	ontributing to death but not resu	ılting in the un	derlying cause give	en in Part I.			ute to the cause of death? Probably 4 □Unknown
page 2 should	Сотріете						24a. Was a autops perform	med? dea	re autopsy findings available for to completion of cause of th? Yes 2 No
i i i i i i i i i i i i i i i i i i i	0 0	25. Was case referred to medical examiner?	Hospital:		2CI DOA Othe	26. Place of Deat			
neral c	- 1	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	4 □ Nursing Ho		ence 6 Other	
Completely filled in by the funeral Medical Constitution		3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Specify)			City or Town	n, State)	or Rural Route Number,
npletely fill)		one)	rsician: To the best of my know iner: On the basis of examinate and manner stated.	vledge, death ion and/or inve	estigation, in my op	oinion, death occur	and due to the cred at the time, d	ause(s) and mann ate and place, and	er as stated. If due to the cause(s)
. = 1 2	Σ	29b. Signature and title of certifier 📜 👚			29c. License	number	2	9d. Date signed (/	Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

AUG 1 5 2007

State of Maryland / Department of Health and Mental Hygiene For State Registrar amend#8 per FH/8/20/07 tm Certificate of Death fchd Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Clarence E. Roberson 18 2007 8:11a /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery

9. Birthplace (State or Foreign Country)
Washington DC Rockville 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 ★M 2 ☐ F May **313**1940 Director 577-54-8229 67 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County show Item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3800 Purdum Drive Funeral <u> 21771</u> United States
14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. be filed within 72 hours after ontal Hygiene. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Service Manager Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental H Ben Roberson ၉ Louise Roberson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trau Phyllis Roberson (spouse) 3800 Purdum Drive Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc. 08/20/07 | Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes P. A. 21. Signature of Funeral Service Licensee 231. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1621 Opossumtown Pike, Frederick, Maryland 21702 Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Physician 4 Months Nonsmall cell lung cancer /Medical Due to (or as a consequence of): Examiner Pulmonary Embolism Day Sequentially list conditions, if any, leading to financial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed use as the burial-transi and Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) P.O. I signed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? this certificate 2 No 2 🔯 No or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ★Inpatient 2 ER/Outpatient 3 DOA 2 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of within 24 hours after deau..

To the Funeral Director: After the funeral by the f 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) August 18, 2007 Bonne MO MD060335 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) # 327 Bonnan Prince Philip Drive 8111 AUG 2 31. Date filed (Mo State 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Registrar

AUG 1 3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** AUGUST Steadman Wible Louise /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MEMORIAL HOSPITAL CUMBERLAND 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. (Month, Day, Year) Aug 10, 1945 Funeral Min 1 ☐ M 2 ☐ F Months Days Hours Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at Fort Loudon PA Franklin Director 10e. Street and Number 10f. Zip Code 17224 P.O. Box 497 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify: ģ 3 ☐ Widowed 4 ☑ Divorced 'natural", th and Mental Hygiene. 7 Is marked other than "natur traumatic event, the Medical I Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lloyd Wible Madeline Ramsev 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 Is any injury or other trau P.O. Box 497 Sharon Wible sister 20b. Place of Disposition (Name of cemetery, crematory or other place)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17224 PA Fort Loudon

Reg. No. 2007

2007

ALLEGANY

4c. County of Death

10g. Citizen of What Country?

USA

Specify: white

20c. Location - City or Town, State

23d. Date of delivery

Month

16b. Kind of Business/Industry

own home

14. Race - American Indian.

10:24 A^M

9. Birthplace (State or Foreign

10d. Inside City Limits

1 □Yes 2 □No

PA

Approximate Interval Between Onset and Death

UNKNOWN

UNKNOWN

UNKNOWN

Year

Day

Clear Ridge Cemetery 8/25/2007 Hustontown 22. Name and Address of Facility
Scarpelli Funeral Home, PA

Date

108 Virginia Avenue: Cumberland, MD 21502 plications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. MULTIORGAN FAILURE DUE TO CERVICAL CANCER Due to (or as a consequence of):

LIVER METASTASIS

Due to (or as a consequence of):

RENAL FAILURE

Due to (or as a consequence of):

2ND DEGREE OBSTRUCTIVE UROPATHY

UNKNOWN

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___

23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? Yes 21 No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No

Day

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) Injury 2 🗆 No 1 Tes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

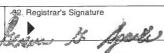
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AIYER, RAVI, M.D., 900 SETON DRIVE, CUMBERLAND, MD 21502

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Ankan



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within 2 To the I

ORIGINAL

Physician Examiner Division or Vital Records, P.O. Box 68760,

attending physician and for use as the burial-transit signed by the a

To the Hospital or Attending Physician:

/Medical

Examine

Physician/Medical

IF FEMALE:

Completed by Be ဥ

Certification:

Medical

State Registrar 27. Manner of Death 1 ☑ Natural 2 Accident

29a. Certifier

3 Suicide 4 ☐ Homicide

1 ☐ Yes 2X No

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

23 art1 Emer the disease, or comshow, or heart failure. List only

determined

5 ☐ Pending investigation 6 ☐ Could not be

Hospital:

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D0065702

2317

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year)

AUG 20

2007

who/completed cause of death (Item 23a) (Tyne, Print)

32. Registrar's Signature

8

cal

28049 State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 12:10 P M 2007 Eloise Speiran 8 17 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Atlantic General Hospital Berlin 8. Date of Birth (Month, Day, Year) 8/28/1919 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🖸 F NY 87 Director 164-54-0408 1001/11/80 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show 1 Yes 2X No Director Bishopville MD Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10729 Bishopville Rd. USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 'naturel', or iteme 11. Marital Status Black, White, etc 1 ☐ Yes 2x No If Yes, Give Year or Dates: 1 Never Married 2 Married DOD Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛣 No Specify: þ 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Nurse Health Care -08/28/19/9 item 27 le marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Selma Pogel Oscar Klino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10729 Bishopville Rd., Bishopville, MD 21813 Ryan Kelchner / grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Depertment of Important: If it eny Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/21/2007 Snow Hill, MD Makemie Cemetery 22. Name and Address of Facility Burbage Funeral Home Funeral Service License 21. Signature 108 William St., Berlin, MD 21811 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Part 1 Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Shock week **Physician** /Medical Due to (or as a consequence of) -07 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine week Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Speiran 3 Ectopic pregnancy Day Month in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 / Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 25 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No i efter death.
I Director: A in by the fu investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 2 29c. License number 29b. Signature and title of certifier D0050826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENIOCA Atlantic General Hoff And 9733 Health may Drive Bertin not 2481 BA10 RAZAAK 31. Date filed (Month, Day, Year) State AUG 2 0 2007 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 28050 Certificate of Death 1. Decedent's Name (First, Middle, Last). 2. Date of Death 3. Time of Death Month 08 Year **Physician** 0633AM 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UMMI Baltimore NIA If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 8. Date of Birth Month Day Year) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2**V**F Months 214-82-908 Couintry) 44 Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Worcester Pocomoke with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n 723 Eighth St. 21851 Funeral USA Pages 1 and 2 should be filed within 72 hours after death ral", or items ? Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☑ Never Married 2 Married 2 🗷 No altimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) than Homemaker Home Ith and Mental Hygier 27 Is marked other the r traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Schoolfield Florence Wise Schoolfield ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If Item 27 is Aneshia Manuel, Daughter 7338 Kelley Loop, Apt. A, Fort Meade, MD 20755 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation Department o
Important: If I
any injury or
once. Frinity U.M. Cemetery 08/25/07 4 □ Donation 5 □ Other Pocomoke, MD Signature of Funera 22. Name and Address of Facility Cooper & Humbles Funeral Co., Accomac, VA Parti. Enter the disc snock, or heart ailu that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. Approximate Interval Between Onset and Death mediate Cause (Final 515 **Physician** disease or condition resulting in death) /Nedical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No To the Hospital or Attending Proyectors within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Minpatient 2 ER/Outpatient 3□ DOA 4 \sum Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 40-11764351115163 08/18/2007 monie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAI Stephanie B. Mikulsky 22 S. Greene St., Baltimore, MD 21201

State Registrar 31. Date filed (Month, Day, Year) AUG 2 0 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 7 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer Month **Physician** 7:40 AM Shaffner -2007 Samuel Kobert /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Buckingham's Choice Health Care Adamstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days Hours 1XM 20 F New Jersey 83 Feb. 15,1924 216-16-9710 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-1 ehow if item 27 is marked other then "neturel", or itema 23a or 28a-f ebov or other treumstic event, the Modical Examinar must be notified at 1 ☐ Yes 2 XNo Adamstown Frederick Be Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21710 3259 Geranium Court permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. In propriant: If them 27 is marked other then "netures", or itema 23a any injury or other treumatic event, the Madical Experience. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married WW II Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) School Administrator Montgomery County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar Harold Shaffner Margaret Karpie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret K. Shaffner/Wife 3259 Geranium Court, Adamstown, MD 21710 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 21 Gate of Heaven Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Ligensee DeVol Funeral Home 10 Fast Deer Park Drive Gaithersburg, MD 20877 TRACY A. Stuck 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gallbladder **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I a.y. leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physicion: The law requires thet the death certificate be executed
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicien and physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No After this certification, 25. Was case referred to medical examiner? 26. Place of Death Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA Certification: To 1 Tes 2 No 1 Inpatient 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 SNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 16/07 D0058726 ·MIN 15t) Yvette Warren M.D. 2,773 30. Name and addr s of person who completed cause of death (Item 23a) (Type, Print) MD Myersville 3000 - P Ventrie Ct. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2007 DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Physician Month Pauline Mae Spickler /Medical ugust 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Mary land 8. Date of Birth (Month, Day, Year) May 26, 1923 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours 1 □ M 2 🖫 F 215-18-1314 84 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1217 Grand Legacy Drive 21740 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 ☑ No f Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Assembler Aircraft Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Taylor Minnie Pearl Smith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Wines (Daughter) 389 Billmyer Mill Rd. Shepherdstown, WV 25443 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 DABurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug.20,2007 | Williamsport, Maryland Greenlawn Mem. Park 21. Sonature of Furieral Service U 22. Name and Address of Facility
Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, Maryland 21795 Portr. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sopres 2 42 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ C Din Galdin 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 4 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 Ho 1 Unpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled in

WH-1

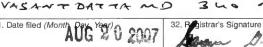
31. Date filed (Month Dec Year) 0 2007 State Registrar

29b. Signature and title of certifier

put mo

29a. Certifier

(Check only one)



340

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

5-1

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

P1081 A

MACERSTOWN

29d. Date signed (Month, Day, Year)

AURUST 17, 2007

21740

MILL

			For State Registrar	State of Ma	ryland /	Departm <i>Certific</i>	ent of F cate of i	lealth ai <i>Death</i>	nd Ment	tal Hygie Reg	ene 2007	28054
	Physici	an	1. Decedent's Name (First, Middle, Last	,		_			- N	ate of Death	Day Year	3. Time of Death
	/Medic	cal	4a. Facility Name (If not institution, give	street and number)	PEE		City Town o	r Location of		gust	17 200 4c. County of Dea	
4	Examir	ier	Washington Count			45.		lagerst				shington
T L	Funeral Director		100 31 1010	x 7. Age	(In yrs. last bi	Mon	nder 1 Year ths Days	If Under 24 Hours	Min. (A	ate of Birth Month, Day, Y	'ear) 9. Bir	rthplace (State or Foreign ountry) PA
	land ow it		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Location						10d. Inside City Limits
	e Mary a-f sho iffied a	ctor	MD Washin	gton		Hag	erstow	m				1 X Yes 2 No
	or 28 be not	Director	10e. Street and Number			1 Of	. Zip Code	0.1.77.6		10g	. Citizen of What Co	•
	leath v ns 23a must	Funeral	904 Chestnut Str	12. Was Decedent Ev	ver in U.S.	13 Was D	ecedent of H	21740		/es or No-	US	
036	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces? 1 ☐ Yes A ☐ No If Yes, Give Year or Dates:			specify Cuba	Specify:	in? (Specify \ Puerto Rican	i, etc.)	Black, Whi	
2-0	72 ho "natur dical	leted	15. Decedent's Edu (Specify only highest grad	lication le completed)	16a	Decedent's	Usual Occup f work done	ation during most c	of working	16	b. Kind of Business	/Industry
7	within iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		ngine					Truck man	ufacturer
Maryland 21215-0036	should be filed wi and Mental Hygien is marked other th sumatic event, the	To Be C	17. Father's Name (First, Middle, Last) Clifford Speer,	Sr.		<u> </u>		18. Mother's	s Name (Firs	t, Middle, Ma	iden Surname)	
Mary	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (T) Darlene Snyder	rpe. Print) sister							City or Town, State, .	Zip Code)
Baltimore,	Pages 1 s nent of He int: If item iry or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemete	of Disposition ery, crematory	or other place		Date		c. Location - City or	
<u>==</u>	g = ± >		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		Green	Hill (- 1				o, PA 17268 al Home, Inc
Ba	permit. F Departme Importan any injur		Sames &	TO OLDAN	4						o, PA 172	
	3 14 1		23a. Parst, Inter the disease, or comp shock, or heart failure. List only o	lications that caused the cause on each line	he death. Do	not enter the	mode of dyin	g, such as ca	ardiac or resp	oiratory arrest	t,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ATHER C			HEA	RT D	IS EA.	SE		Onset and Death
	Examiner		Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Due to (or as a consequence of):									
	pa tis	iner	Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury	Due to for as a	consequence	of):						
_6	xecute and	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence	of):						
68760	ificate be executed g physician and as the burial-transit	edical E		d	·	, 						
_	<u>*=</u> D #	Med	IF FEMALE:									
O. Box	The law requires that the death certifithe has been signed by the attending age 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome pt 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	☐ Fetal death	n 3⊟Ectop 5⊟Other	ic pregnancy r (specify)				23d. Date of de Month	livery Day Year
٦.	ires that the de signed by the a be detached f	by Ph	Part II. Other significant conditions co	ntributing to death but	not resulting i	n the underlyi	ng cause give	en in Part I.	2	3e. Did tobac	cco use contribute to	o the cause of death?
Örğ	w require been sig should b								_ [1 ☐ Yes	2 No 3 €	robably 4 Unknown
Vital Records,	e law r has be	Completed							2	4a. Was an autopsy	prior to	utopsy findings available completion of cause of
ē			25. Was case referred to medical					00 5		/	d? death? Xyo 1 ☐ Yes	3 2 □ No
>	Physician: this certifical	To Be	examiner?	lospital: 1 ☐ Inpatient	2 ER/O	utpatient 3	DOA Othe	ar.	of Death (Che		e 6 ☐Other (Spe	ecify)
n or	ding Ph h. After thi funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury	28c. Injury Work	/ at	28d. C		injury occurred	
UIVISION	Attending Physician: or death. ector: After this certification by the funeral director,	ficati	2 Accident investigation 3 Suicide 6 Could not be 4 Demicide determined	28e. Place of injury	r - At home, fa	M arm. street, fac		Yes 2 □ No		ocation (Stree	et and Number or Ri	ural Boute Number
S	Ital or a safter ral Dire	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)				C	ity or Town, S	State)	arar i Touto i turrizor;
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	ledical	one) 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	xamination ar	e, death occur nd/or investiga	ition, in my o	pinion, death	place, and de occurred at	ue to the caus the time, date	se(s) and manner as e and place, and due	s stated. e to the cause(s)
	with Voint	Σ	29b. Signature and title of certifier	11	M.D		DOO C	number	1	29d	Date signed (Mont	
ث ۵	2H-5		30. Name and address of person who co	ompleted cause of dea	th (Item 23a)	(Type, Print)	1eclica	1 Can	prs Ro	1 561	,	erstown 21742
	Sta	te	31. Date filed (Month, Pay Year) AUG 21 20			Source			1	1 - 100	INT) 11144
	Registr	ar	AUG 2 I Z	Hal Been	J. J.	Spent	U					

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

		For State Registrar		Maryland / Dep		lealth and M	ental Hygie						
Physici /Media		Decedent's Name (First, Middle, Adeline J. Sherman	Last)				2. Date of Death Month August (7, 2007 Year	Time of Death				
Examir	ner	4a. Facility Name (If not institution, 309 E. Main Street				r Location of Death Frostburg		4c. County of De Allegany	ath				
Funeral Director		5. Social Security Number 216-22-7481 Usual Residence of Decedent	6. Sex 7. 1 □ M 2 1 F	Age (In yrs. last birthda 80 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo May 20	5, 1927 9. B	irthplace (State or Foreign West Virginia				
with the Maryland a or 28a-f show be notified at	ctor	10a. State 10b. County	egany	10c. City, Town or Frostburg					10d. Inside City Limits 1 Yes 2 □ No				
th with the 23a or 28a ist be not	al Director	10e. Street and Number 309]	E. Main Street		10f. Zip Code 21532-			Citizen of What C	Country?				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ▼ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	₩ No	B. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, uite, etc. Vhite				
d within 72 ho giene. Ir than "natui the Medical	Be Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education t grade completed) O College (1-4c	(Giv	cedent's Usual Occup ye kind of work done o . DO NOT use retired k	ation during most of workii 1)	ng	b. Kind of Busines	s/Industry				
uld be file Mental Hy, arked othe	To Be C	17. Father's Name (First, Middle, L Casper Higgs	ast)			18. Mother's Name Katie Tho		den Surname)					
and 2 sho ealth and I n 27 Is me		19a. Informant's Name/Relationshi Carla Cook	ip (Type. Print) daug	thter 25	iling Address (Street) Manor Knoll Co	ourt	Baldwin	ity or Town, State, Marylan					
Pages 1 ment of H ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		. cemetery, ci	position (Name of rematory or other place e Methodist Co	ce) ;		t. Savage					
permit. Departi		21. Signature of Funeral Service L	icensee R. Wux	est	22. Name and Addres Durst Fune	ss of Facility ral Home, 57	Frost Ave., F	rostburg, M	D 21532				
eath certificate be executed attending physician and for use as the burial-transit	dical Examiner	23a. Pal Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Approximate Provided Provide											
law requires that the death certificate as been signed by the attending phys. 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25th No 9 □ Unknown		n 2 ☐ Fetal death 3 t at time of death 5	B Ectopic pregnancy	1		23d. Date of d Month	elivery Day Year				
w requires that the d been signed by the should be detached	þ	Part II. Other significant condition	ns contributing to death	h but not resulting in the	underlying cause give	en in Part I.		co use contribute	to the cause of death?				
The ate has page	Completed						24a. Was an autopsy pertorme 1∐ Yes 2.	d? prior to					
Physician this certif al director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			4 Nursing Hor	ne 5 Residenc		pecify)				
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification in the funeral director, to the funeral director, the funeral director.	Certification:	27. Manner of Death 115 Natural 2	ation of be 28e. Place of	njury Day Year) 28b. Time Injury	M 1 □	Yes 2 □ No	28f. Location (Stree City or Town, S	t and Number or I	Rural Route Number,				
e Hospital 24 hours a e Funeral etely filled	ledical Ce			est of my knowledge, des s of examination and/or stated.									
To the within O C comple	Me	29b. Signature and title of certifier	·		29c. Licenson	1	29d.	Date signed (Mod	nth, Day, Year)				
n lls Sta	te.	30. Name and address of person were the Country of	who completed cause of P35 Bish 32 Regi	of death (Item 23a) (Type op	ROAD	Cumber	LAND,	m) o	21502				
Registr		AUG 0 7 2	2007 /200	see It A	perte								

Amended #18, n1s, 08/13/07, Allegany Co. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007

		Registrar 1. Decedent's Name (First,	Middle, Las	it)		Cer	tificate of l	Jeath	2. Date of I				3. Time of Death
hysicia /Medic		Kenneth A. Steven							Month Aug	ust 08	Day 3, 2007	Year	07:45 A
xamin	-	4a. Facility Name (If not inst	itution, give	street and number)			4b. City, Town, or	Location of De	ath		4c. County of		
		WMHS - Braddoo 5. Social Security Number	k Camp		e (In yrs. lasi	t hirthday)	If Under 1 Year	umberland If Under 24 H			Allegany		nlane (State or Fore
eral		214-28-6542 Usual Residence of Decede	1	№ 2□ F	75	Yrs.	Months Days	Hours M		Day, Ye	ar) 931	Mary	place (State or Fore ntry) and
the Medical Examiner must be notified at		10a. State 10b. C			10c. City, T	Town or Lo	cation						10d. Inside City Lim
offitte	Director		llegany		Frostb	-				1.0			
2		10e. Street and Number 10	226 Pin	ey Mountain I	Road, S.V	V .	10f. Zip Code				Citizen of W	hat Cou	ntry?
	Funerai	11, Marital Status		12. Was Decedent	Ever in U.S.	13. \	21532- Was Decedent of H f Yes, specify Cuba	ispanic Origin?	(Specify Yes or	_U.S.	14. Race		can Indian,
Militar	by Fur	1 Never Married 2		Armed Forces? 1 Yes 2 M If Yes, Give Year or Dates:	No		fYes, specify Cuba 1□Yes 2021 No	n, Mexican, Pu Specify:	erto Rican, etc.)		Specify:	c, White, White	
	ted	15. Dec	edent's Ed	lucation	1	16a. Deced	lent's Usual Occup	ation		16b	. Kind of Bu		
	Completed	(Specify only Elementary/Secondary (0	-	de completed) College (1-4or	5+)	life. L	kind of work done of DO NOT use retired	during most of v ()	vorking				
	Con	8	0		ŀ	nousek	eeping			_	e univer		
B V B L	Be	17. Father's Name (First, M	ddle, Last)						lame (First, Midd			B)	
Hatte	ည	Alan Stevens 19a. Informant's Name/Rei	itionship //	Tyne Print)		19h Mailin	g Address (Street	Alice Kitt				State Zi	n Code)
other traumatic		Kenneth A. Steve		son	- 1	222			Frostbur		Marylar		21532-
other	Ŋ.	20a. Method of Disposition			20b. Plac		Satherine St. I sition (Name of natory or other place		Date		Location -		
		1 Burial 2 □ Crema '4 □ Donation 5 □ Otl					morial Park	1	ust 10, 2007	Fros	tburg	Мат	yland
any injury or ODCB.	Ì	21. Signature of Funeral Se			1105101	-	. Name and Addres		ust 10, 2007	100	, to any	11100	,
any ir		John	R	Ruch	7	Г	Ourst Funeral	Home, 57	Frost Ave	Fros	tburg, M	ID 21	1532
4		23a. Part. Enter the disea	se, or comp	plications that cause	d the death.	Do not ent	er the mode of dyin	g, such as card	iac or respiratory	arrest,			Approximate Interval Between
ian		Immediate Cause (Final disease or condition			H D							V	Onset and Deat
cal		resulting in death)	-	d	a consequer	nce of):						y	Cars
ner		Sequentially list conditions, Due to (or as a consequence of):											
5	inel	Sequentially list conditions if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury	~	Due to (or as	a consequer	nce of):							
5	Examiner	that initiated events resulting in death) Last		c Due to (or as	a consequer	nce of):						-+	
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TOT USE AS		IF FEMALE: 23b. Was decedent pregna	nt	23c. If yes, outcome			Tetasia erosaana				23d. Date	of deliv	very
2	Physician/M	in the past 12 months 1 ☐ Yes 2 ☐ No		4☐Pregnant a			Ectopic pregnancy Other (specify)			-	Mon	ith	Day Year
Dell'on la	hys	9 Unknown											
90	ρ	Part II. Other significant co	nditions c	ontributing to death t	out not resultii	ng in the ui	nderlying cause giv	en in Part I.					the cause of death bably 4 M Unkn
250	Completed								-				
ν Ν	mple								24a. W	as an topsy rformed	9	Vere aut rior to co eath?	opsy findings avail ompletion of cause
200										2 🕏			2 No
	Be	25. Was case referred to mexaminer?	edical	Hospital:			Oth		eath (Check oni		-		
5	. To	1 Yes 2 No 27. Manner of Death		1 🗆 inpati		VOutpatien Bb. Time of			Home 5 Re				ify)
	ţ		ending vestigation	28a. Date of Inju (Month, Da	y Year)	Injury	Wor	k? Yes 2. □No					
	Certification:	3 ☐ Suicide 6 ☐ 9	ould not be	28e. Place of In	jury - At home	e, farm, str	eet, factory, office					er or Rui	al Route Number,
	ert	4 Homicide		building, e	tc. (Specify)				City or	Town, St	rate)		
etely IIII	Medical C	29a. Certifier 1 Ce (Check only one) 2 Ma	rtifying Ph dical Exan	ysician: To the best niner: On the basis of and manner st	of examination	edge, death n and/or in	n occurred at the tin vestigation, in my o	ne, date and pla pinion, death o	ice, and due to the courred at the time	ne cause le, date	a(s) and mar and place, a	nner as ind due	stated. to the cause(s)
comple	Me	29b. Signature and title of c	ertifier	/ //			29c. Licens	e number		29d.	Date signed	(Month	, Day, Year)
/)	, /	11/	· m		D 0	9157		Αι	ıg 8	200	7
0		30. Name an address 1	erson who	completed cause of	death (Item 2	3a) (Type.	Print)			1	-	1.51	
						, , , , pp,							
125		Paul Smor	, M.	D., Dpt	v Med	Ex	124 W 31	rd St	Cumber	land	dM E	215	02

07-06484 Lauro Saldano

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 28057

			1- For State Certificate of Death	Reg.	No.	
	Physici	an/	1. Decedent's Name (First, Middle, Last)	Date of Death Month D	av Year	3. Time of Death
Vled	ical Exami	ner		August 21, 2	2007	1102 hrs
			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Laurel Hospital Laurel	n	4c. County of Death Prince George	's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	s. 8. Date of Birth(MM/DD/YYYY) 9. Birti	nplace (State or MD
	Director		220-75-6762 1x M 2 F 1 Yrs. Months Days Hours Mir		Foreigi	ntry) U.S.A.
	an y		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
ō	* .	_	MD Prince George's Laurel			1 X Yes 2 No
2	Aaryland 28a-f show 1 at once.	Director	10e. Street and Number x2 10f. Zip Code	10g.	Citizen of What Coun	try?
_	ith the Maryland 23a or 28a-f sho notified at once.		9104 Scott Adams CT. Apart 20708	Un	ited State	
	h with rms 23 be no	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S 14. Why were Married 12. Married Armed Forces? 14. Was Decedent of Hispanic Origin? (S 15. Was Decedent of Hispanic Origin? (S 16. Yes, specify Cuban, Mexican, Puerty		14. Race - Americ	an Indian, Black, İspanic
	hours after death with the Maryland 'naturial'', or items 23a or 28a-f shr Examiner must be notified at once	F	1 Yes 2 X No			ican Indian
	rs afte ural",	্র	or Dates:		6b. Kind of Business/Ir	
	136 thin 72 hours a te. than "natural edical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			at result felle access
	5-0036 iled within 7 Hygiene. I other than the Medica	g l	O NONE	1 15	NONE	
	D 21215-0036 should; be filed within 72 and Mental Hygiene. 7 is marked other than "natic event, the Medical.		17. Father's Name (First, Middle, Last) 18. Mother's Nam	e (First, Middle, Ma	den Surname)	
	2121 ould be fil Mental F marked ic event,	o Be		a Saldana	Madariaga	Tip Code)
	MD 2 d 2 shoul tth and N n 27 is m tumatic	-	(Mother)			
	医克斯克斯	,	20 - Note of Disposition (Nome of compton)		20c. Location - City or	
	F 8 7 F 3		1 X Burial 2 Cremation 3 Removal from State Panteon: Ejidal 09	/ / / / / /		Buenavista
	Baltimo permit. Page Department o Important: Injury or otl		4 Donation 5 Other Specify: 1. Signature Funera ce Lic 22. Name and Address of Facility Sat	nta Cruz	Chiapas. M	exico.
	Balt permit Depart Impor Injury	23.0	Sandagh William 600 Kennedy ST. N	W: Washin	gton. D.C.	20011
4.	Physician	7.—7.4	23a. Part I. Enter the diffease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
,	/Medical xaminer		Immediate Cause (Final disease a. Viral syndrome			Death
		0	or condition resulting in death) Due to (or as a consequence of):			
		Ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	_	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in fearth.) Last Due to (or as a consequence of):			
	ecuted and - transit		events resulting in death) Last Due to (or as a consequence or): d.			
	ial ial	/Medical	X AMENDED X AMENDED #9, perFH, #1,23a,27,perME,g872, 10/9/07 TT	1		
	Box 68760, c death certificate be the attending physic do for use as the bur	/Me	IF FEMALE: 23C. If yes, outcome of pregnancy		23d. Date of delivery	
	Sox 68 leath certiff eath certiff for use as f	sician	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregr	nancy	Month E	Day Year
	Box e death the atte	ysi	1 Yes 2 No 9 Unknown 9 Unknown			
	P.O. es that the gned by the detache	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	F===1
	S, P.(nires that n signed d be deta				2 No 3 Prot	
	Vital Records, hysician: The law require this certificate has been si I director, page 2 should b	Completed		24a. Was an autopsy	prior to c	topsy findings available completion of cause of
	Rec The la cate ha	mo:		perform 1 Y Yes 2		es 2 No
	ital Recicion: The sectificate	BeC	25. Was case referred to medical Zo.Place of Death (Check			
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	n of ding Ph			28d. Describe ho	w injury occurred	
+	Sion Attend r death ectors by the	cati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Str	eet and Number or Ru	ral Route Number, City
	Division pital or Attendiours after death.	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, Sta		,
	Hos 24 h Fun ely	S S	29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	nd due to the cause(s) and manner as stat	ed.
	To the Howithin 24 h To the Fur	edical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date ar	nd place, and due to th	e cause(s)
	L % F S	Me	29b. Signature and title of certifier		29d. Date signed (Mo	
			Carol Hallan O.C.M.E.		August 22, 2007	
n	2		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	01		
1	10%	ا ا				
	S Regis	tate				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Joseph Bryant Sparks 12:30P M August 16, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 125 Allnut Court Apt 411 Prince Frederick Calvert 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 69 1**X** M 2□ F Director Nov 27. 1937 Wash. D.C. 579-50-1791 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene. sant of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 125 Allnut Court 20678 USA Funeral Apt 411 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Tyes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White þ Specify: 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Construction Painter College (1-4or 5+) 12 Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Bryant Sparks John Marguerita Zanelotti 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Noccolino (brother) Road Woodbury, NJ 08096 1318 Barnesdal 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Aug 18 permit. Pages 1 Department of H Important: If Ite any Injury or ot once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Lee Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA Cary J. Geff 8125 Southern Maryland Blvd Owings, MD 20736 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bearing to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Division or Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ၉ 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated within 2 To the

State Registrar

29b. Signature and title of certifier

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 11 Registras Signature 110 Hospital Road, #310, Prince Frederick, MD 20678 Jonathan D. Lowenthal 31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year) August 16, 2007

BERLIA.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** August 15, 2007 10:00 aM Franklin Self, Jr. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Ctr-Hospice of Baltimore Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months 1 M 2 □ F 70 Director 219-34-8889 Jan 20, 1937 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 🛠 📉 No Directo MD Carroll Sykesville 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21784 USA 2605 Bomek Circle 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XX No Specify: White Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Disc Jockey</u> AM Radio 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Leroy F. Self, Sr. Margaret L. James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any Injury or other traum once. 2605 Bomek Circle, Sykesville, MD 21784

ce of Disposition (Name of Date 20c. Location - City or Town, State Shirley Jean Self 20b. Place of Disposition (Name of cemetery, crematory or other place) NyBurial 2 □Cremation 3 □Removal from State eaven Cemetery Aug 20, 2007 | Silver Spring, MD

22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 21. Signature of Funeral Service Licensee Ken Stele 500 University Blvd. W, Silver Spring, MD 20901 23a. P. D. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CANCER OF THE MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner death certificate be executed Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Ö 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by No 3 Probably 4 Unknown 1 ☐ Yes Record 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 24 hours after death e Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 6565 N. CHAPLES ST., SWITE 216, TONSON, MD 21204 DANIEUT DOBERMAN, MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

3altimore, Maryland 21215-0036

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Physician
/Medical
Examiner

Dir

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heetth and Mental Hygiene.

Baltimore, Maryland 21215-0036 Cherry Thomas

> Phys /Me Exan

Division of Vital Records, P.O. Box 68760, 😤 To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

	Registrar			007	iniouto oi	D Outil	ne ne	g. 140.		
cian	1. Decedent's Name (First, Middle Cherry M. Tho						2. Date of Death Month August	Day	Ž ^{ea} ro 7	3. Time of Death 5:25 PM
cal	4a. Facility Name (If not institution,		r)		4b. City, Town, o	or Location of Death			y of Death	
er	Genesis Heal			Dines	East				albot	
				last birthday)		If Under 24 Hrs.	8. Date of Birth	1		place (State or Foreign htry)
	081.14.2122	1 □ M 2 🛣	91	Yrs.	Months Days	Hours Min.	(Month, Day,	Year) 1916	Nov	York
	Usual Residence of Decedent		ЭT				Aug. 10	, 1910	TICH	VIOLK
	10a. State 10b. County		10c. Cit	y, Town or Loc	ation					10d. Inside City Limits
č	Manual on d To 1h		1	T.7						1 ☐ Yes 2 📉 No
Š	Maryland Talb	OL		Wittman			10	Og. Citizen of	What Cou	ntn/2
E	10e. Street and Number 22574 Pot Pie Re	a			10f. Zip Code 216	76	1 "	•	SA	indy?
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Funeral Director	11. Marital Status	12. Was Deceder Armed Forces ed 1 ☐ Yes 2 2	nt Ever in U. ເ?	.S. 13. V	Vas Decedent of H Yes, specify Cub	lispanic Origin? (Spana) an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ack, White,	can Indian, , etc.
	1 Never Married 2 Marri	ed 1 ☐ Yes 2 2 If Yes, Give	No No	1	☐ Yes 2 No	Specify:		Spec	ify: D1 -	1-
ģ	3 X Widowed 4 □ Divorced	Year or Dates	:		**				DIS	
Completed	15. Decedent (Specify only highes			(Give	ent's Usual Occup	during most of work		16b. Kind of I	Business/Ir	ndustry
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Bec	17. Father's Name (First, Middle, I	Last)				18. Mother's Name	e (First, Middle, M	Maiden Suma	me)	
To B	John Lucas					Hattie 7	Chompson			
F	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailin	g Address (Street	and Number or Run	A	City or Town	n, State, Zij	p Code)
	Elizabeth Simon		or	2257	Dot Di	e Rd., Wit	tmon MD	21676		
	20a. Method of Disposition	cilii/ Daugiit	20b. F	Place of Dispos	sition (Name of			20c. Location		own, State
	1 Burial 2 Cremation	3 □Removal Irom Stat	_			ce)		ambrid	oe M	ID.
	4 □ Donation 5 □ Other (Sp		Mid	ShoreCi	remation(Center 8/2	24/2007		60, 1	
	21 Signature of Funeral Service I	icensee		Ŋ.	Name and Addre	cremation	Center	- MD	21612	•
	Mocked tolk	de son	le	ees -	7777 Hud	ison ka.,	Cambrida	ge,MD	21013)
	23a. Part1. Enter the disease, or	complications that caus	ed the deat	h. Do not ente	er the mode of dy	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between
	shock, or heart failure. List	only one cause on each			diomy	anoth.				Onset and Death
	disease or condition resulting in death)	a. 150			arom	pring				years
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_	Sequentially list conditions,	b. 179/12	as a conseq	2/2//						Jens
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	4 6.		2103,5						geers
E	that initiated events resulting in death) Last	C)
	1650iting in Goatin) Last	Due to (or a	as a conseq	uence or):						
Ca		d								
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⋛	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			I				ate of deliv	,
	in the east 12 months?	1□Live birth 4□Pregnant			Ectopic pregnanc Other <i>(specify)</i> _			λ	fonth	Day Year
Physical	1 ☐ Yes 2 ☐ No 9 ☐ Uriknown	9□ Unknown								
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ple							24a. Was ar autops	V	prior to co	opsy findings available ompletion of cause of
Completed							perfore 1 ☐ Yes 2	ped2	death?	2 □ No
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$\mathbf{\omega}$	examiner?	Hospital: 1 ☐ Inpa	atient 2	ER/Outpatien	t 3 DOA Ot		me 5 Reside		ther (Spec	ify)
- To	27. Manper of Death	28a. Date of Ir	njury	28b. Time of			28d. Describe ho			
Certification:	Natural 5 Pendin	g (Month, I	Day Year)	Injury		ork?]Yes 2 □ No				
cat	2 Accident investig		Latina de la			1.00	281 Location (St	reet and Nur	nher or Pu	ral Route Number,
Ħ	4 Homicide determ	ined 200. Place of	etc. <i>(Specil</i>	ome, tarm, str fy)	eet, lactory, office		City or Town		ilbei oi nui	rai modie ivamber,
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ca	29a. Certifier Certifyin	g Physician: To the be Examiner: On the basis	st of my kno	owledge, death	occurred at the t	ime, date and place, oninion, death occur	and due to the ca	ause(s) and rate and olace	nanner as	stated. to the cause(s)
edical	one)	and manner		and and or in	rosugation, in my	Spiritori, double occur				
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	30. Name and address of person	who completed cause a	f death /Ites	m 23a) (Type	Print)		-			
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	31. Date liled (Month, Day, Year)	~ n-1	strar's Signa	ature 4	<u> -[11.11]1/.</u>	J KINE	1131	0,0		~1001
ate	u o i. Dale med (Month, Day, 19ar)	₩Z. negi	war a digit		All a					

State

Registrar

AUG 3 1 2007

		•	For State Registrar	State of Ma	ryland / [nent of He cate of D		Mental	Hygier Reg. I	2007	28061
			1. Decedent's Name (First, Middle, Las	st)					2. Date Mont	of Death	Dey Yeer	3. Time ol Death
	Physicia /Medic		Charles Tr	20253-					8		8 200	M 01:10 4
	Examin		4a. Facility Name (If not institution, give	street and number)		4b.	City, Town, or	Location of Death	1		4c. County of De	ath
			BAITINDEE VAP		SHIEL	45-45-17 1911	Inder 1 Year	II Under 24 Hrs.	8. Date	of Dieb	MIA	rthplace (State or Foreign
	Funeral Director		5. Social Security Number 146-16-8076 6. S	ex 7. Age □ 2 □ F	(In yrs. last bir		nths Days	Hours Min.	(Mon	th, Day, Yei	ar) Not	Persey
	ס		Usual Residence of Decedent						- 07	17/17	<u> </u>	
	anylan show	_	10a. State WV 10b. County Jeffe	rson	10c. City, Tow	n or Location les To						10d. Inside City Limits Y Yes 2 □ No
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	be filed within 72 hours after death with the Maryland thygiene. Hygiene 4 hygiene 4 hygiene 4 hebw of other than "netural; or tleme 23a or 28a-f ehow avent, the Madical Examiner must be notified a avent, the Madical Examiner must be notified a	Funeral Director	518 South George	Street Ap	t. C-2	10	^{r. Zip} 2541	4		109.	United	States
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٥	filed within 72 hours after Hygiene. ther than "netural", or Ita the Medical Examina		1 X Never Married 2 ☐ Married	Armed Forces? 1X Yes 2 □ No If Yes, Give			es 2X No	Specify:	o nican, ei	ic.)	Black, Wh	h it e
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2	al Hygi al Other vent, I	Bec	17. Father's Name (First, Middle, Last) Charles Traverse					18. Mother's Nam B lanc h	ne (First, A	Middle, Maid	len Şumame) N TON	
yland	2 should be and Mental I a marked o	2										
Mar	es 1 end 2 should E of Heelth and Ment fitem 27 le markec r other treumatic		19a. Informant's Name/Relationship (Robert J. Bucci/		196	1 Hamr	mond La	ne, Shep	pherd:	S town :	W 2544	Zip Code) 3
Se,	of Hee		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 🔀	Demousl from State	20b. Place o cemete	f Disposition ry, crematory	(Name of y or other place)	Date	20c	Location - City of	r Town, State
Ĕ	Peg ment ant: h		4 ☐ Donation 5 ☐ Other (Specif	y)	Culpe			Cemeter			Culpep	er, VA
Баппо	permit. Peges Department of the Important: If its any injury or of once.		21. Signature of Funeral Service Licer	1500				Strider Charles			25414	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ceused to	the death. Do							Approximate Interval Between
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0			IF FEMALE:									1.
X Q Q	death certific e attending pl id for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal death		pic pregnancy				23d. Date of d Month	elivery Day Year
o o	the de y the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant al t 9□ Unknown	ime of death	5 Li Otne	er (specify)					
J	w requires that the de been signed by the s should be detached i		Part II. Other significant conditions of	ontributing to death bu	t not resulting i	n the underly	ring cause give	n in Part I.	23е	. Did tobacc	co use contribute	to the cause of death?
cords	requires that seen signed b hould be deta	ed by								1 🗌 Yes	2 No 3 1	Probably 4 Unknown
000	law red as bee 2 sho	Completed							24a	. Was an autopsy	24b. Were	autopsy findings available completion of cause of
r	The ete h	EO							10	performed Yes 2	? death'	2
VII	ysician: Th is certificete director, pag	Bec	25. Was case referred to medical examiner?					26. Place of Dea	th (Check	only one)		
5	S S D	၉	1 ☐ Yes 2 No	Hospital: 1 Inpatier			DOA Othe	4 Ivuising n			6 Other (Sp	pecify)
	D 0 0	tlon	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Oate of Injury (Month, Day		Time of Injury M	28c. Injury Work	at ? ′es 2 ∐No	280. Des	cribe now ii	njury occurred	
UIVISION	al or Attending Ph s atter death. t Director: Atter th d in by the funeral	fica	3 Suicide 6 Could not b	e 28e. Place of Inju	ry - At home, la							Rural Route Number,
É	2 = -	Certification:	4 Homicide determined	building, etc.	(Specify)				City	or Town, S	tate)	
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical C	29a. Certifier (Check only one) Certifying Ph	nysician: To the best of niner: On the basis of and manner state	examination ar	e, death occu nd/or investig	urred at the tim jation, in my op	e, date and place inion, death occu	, and due irred at the	to the cause time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
	orthin (Mec	29b. Signature and title of certifier	and mainer star			29c. License	number		29d.	Date signed (Mo	nth, Day, Year)
	r s r ō		· M				0	1031		1	18	2002
-			30. Name and address of person who	completed cause of de	ath (Item 23a)	(Type, Print)				1	7	12007
X	1-4+1		DAVID CHESLS	2 Ms	601	GOSS	NE ST	Bar	TIMO A	Q1 2	21201	
	Sta Registr		31. Date liled (Month, Day, Year) AUG 22	32. Registra	r's Signature	ha	No.					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, 28062 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician 355 CENNETH 0 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Frederick Calvert 813 Calvert Towne Drive If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1XM 20 F 257-48-1449 Yrs 70 Géorgia Director Oct 31, 1936 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f shov must be notified at MD 1 ☐ Yes 2 XINo Prince Frederick Calvert Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 813 Calvert Towne Drive 20678 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. Examiner 1 Never Married 2 Married 5 1 ☐ Yes 2 💆 No Baltimore, Maryland 21215-0036 Specify: Specify: Black þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than " Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Auditor Budget Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be 7 is marked o traumatic eve Bertha Kate Edwards James D. Thorpe ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trau once. Annette Thorpe /Wife P.O. Box 907 Prince Frederick, MD 20678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 08/20/07 Patuxent UM Church Cemetery Huntingtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician MALIGNANT /Medical Due to (or as a consequence of): **Examiner** CANCER- TO BRAIN -TASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a the burial-1 Division or Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an nas e 2 s page certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No 3∏ DOA ၉ 2 ER/Outpatient 5 Residence 6 □Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: , I in by the f 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 0-0062080 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hunfingtown, MD 20639, STANLEY 665 5 Ri 31. Date filed (Month, Day, Year) 32. Registra State 1 6 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** VANMETER HESTER 11:48A^M AUGUST 24. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY CUMBERLAND MEMORIAL HOSPITAL Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) if Under 24 Hrs 8. Date of Birth (Month, Day, Year) Jan 6, 1938 **Funeral** Days Hours Months 1□ M 2□ F Director 214-42-0717 69 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Innent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Oldtown Allegany Y□Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21555 USA 15701 Cresap Mill Road SE Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Completed by Specify: 3X Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 production worker Abex Corporation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blair Edward Peer Evelyn Marie (Farris) Peer ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21555 16002 Walnut Ridge Rd. Oldtown Brenda Bishop daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Important: If Its any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Oliver Grove Cemetery 8/27/2007 MD Oldtown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fineral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 23a-Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRHYTHMIA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death **Physician** MINUTES /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE
Due to (or as a consequence or): YEARS Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner DIABETES MELLITUS YEARS the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical use as attending for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t autopsy perform 2 No 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ▼ER/Outpatient 3 DOA 27. Manner of Death within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day) 28b. Time of Injury at Work? 28d. Describe how injury occurred Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) D54411 AUGUST 24, 2007 on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers 0 SUITE 105, CUMBERLAND, MD 21502 500 MEMORIAL AVE., CALKINS, DR. BEVERLY

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 3 1 2007

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Robert N. White 7:20 A M 24, August 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ruxton Health of Denton Denton Caroline 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 213-22-6498 1**X** M 2□ F 80 yrs. Nov. 9, 1926 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Integrant; if them 23s or 28s-f show any fully or other traumarke than "matural", or items 23s or 28s-f show any fully or other traumatic event, the Merical Examiner must be notified at Caroline MD 1 ☐ Yes 2 ☑ No Director Federalsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2718 Guard Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1★1Yes 2 No If Yes, Give Year or Dates: 45-65 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: 2 Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Naval Officer United States Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Car1 D. White Wagner 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael White/Son 2558 Guard Road, Federalsburg, MD 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bethel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Aug. 27, '07 Federalsburg, MD 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL **Physician** /Medical **Examiner** 420 512820TIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No autopsy performed? Yes 2 2 No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide reactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
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rho completed cause of death (Ipon 23a) (Type, Print) 上いれるが、MU)ス21(

32 Registrar's Signature

AUG 2 8

2007

31. Date filed (Mo.

State of Maryland / Department of Health and Mental Hygien 2007 28065 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 11:58 P^M August 14, 2007 Mary Lucille Williams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner National Lutheran Home Montgomery Rockville 8. Date of Birth (Month, Day, Year) June 15, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 246-26-8594 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 83 1 □ M 2 XF Yrs 1924 North Carolina Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits wode ! rthen "neturel", or iteme 23a or 28e-f ehov tre Medical Examiner must be notified at Maryland Montgomery Rockville 1 XYes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5825 Crawford Drive 20851 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ĀNo If Yes, Give Year or Dates: 1 Never Married 2 Married lore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced White leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e tiled within al Hygiene. other then " Compl Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be tile Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Redmond Lillian Heath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha A. Harbaugh/Daughter 7004 Cypress Hill Drive, Gaithersburg, MD 20879 20b. Place of Disposition (Name of MD Cometer) crematory or other) Date 20a. Method of Disposition 20c. Location - City or Town, State August 20, Cheltenham, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 4 □ Donation 5 □ Other (Specify) 2007 Maryland 21. Signatura of Funeral Service Liceus 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive, Gaithersburg, MD 20877 or complications that caused the death, ist only one cause on each line. 23a. Par . En er disease, or com shick, or a disease, or com So not enter the mode of dying, such as cardiac of respiratory arrest, Approximate Interval Between Onset and Death Immediate Causey (Findisease V condition resulting in death Physician /Medical Examiner Leav Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) à signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. vision of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate 1 Yes 2 NO Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No vendir, r death. tor: After th. e funeral div 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident To the Hospitel or Attent within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 Homicide 29a. Certifier 1 Centifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintain and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Ceftifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 21126 aresh 30. Name and address of person who completed cause of death (Item 23a) Type, Print) Charles W. Karesh, M.D., 9701 Viers Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 28066 Certificate of Death 2. Date of Death 3. Time of Death Day DAWN WRIGHT AUGUST 19, 12:05 P M 2007 4b. City, Town, or Location of Death 4c. County of Death

9. Birthplace (State or Foreign

Physician KATINA /Medical 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Year) Oct. 12,1972 West Virginia If Under 1 Year | If Under 24 Hrs. Social Security Number 234-11-8037 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ XF Months Days Hours 34 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at WV Jefferson Kearneysville Director 10e. Street and Number 2790 South Childs Road 10f. Zip Code 25430 Funeral death 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 M Married 2 XX Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "in any filury or other traumatic event, the Media once. Elementary/Secondary (0-12) College (1-4or 5+) Trainer 17. Father's Name (First, Middle, Last) Be Asa D. Brewer Deborah Griffith 19a. Informant's Name/Relationship (Type. Print) Ronald A. Wright/Husband 20b. Place of Disposition (Name of Date 20a. Method of Disposition Edge Hill Cemetery XXBurial 2 Cremation 3 Removal from State 8/23/07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa re of Funeral Service Licensee Melvin T. Strider Co., Inc. PO Box 388, Charles Town, WV 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CENESMA ESEMA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes Completed 24a. Was an autopsy performed? Yes 22 No 1∐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1. Inpatient ၉ 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: Injury 1 Natural 5 Pending M investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide completely filled in by 4 Homicide the Hospital and manner stated. 29c. License number 29b. Signature and title of certifie 1)44213 (MD) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 05H-4

10d. Inside City Limits 1 □ Yes 2/CXNo 10g. Citizen of What Country? United States Black, White, etc. White Specify: 16b. Kind of Business/Industry Mail Order 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2790 South Childs Road, Kearneysville, WV 25430 20c. Location - City or Town, State Charles Town, WV Approximate Interval Between Onset and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) Drive T.T. # 200 Commente. 31. Date filed (Month) 32. Registrar's Signature State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 2	8067
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		- For State	Certi	ficate of	Death		Reg	No.	
Physicia		1. Decedent's Name (First, Middle,Last)					Date of Death Month I	Day Year	3. Time of Death 1337 hrs
Medical Examir			ILLIAMS		4: Ott. T as I	eastion of Day	August 15,	2007 4c. County of D	
*		4a. Facility Name (if not institution, give University of Maryland	street and number)		4b. City, Town, or I Baltmore	Location of Dea			
Funeral	1	5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days		din	F	J. Birthplace (State or oreign
Director		240-80-3755 1 XI	M 2 F 58	Yrs		Hours	Nov. 2	5, 1948	Country) NC
,	muga was	10a. State 10b. County	10c. City, T	own or Locat	ion		T V		10d. Inside City Limits
≥	L.	VA	A	Lexand	ria		1.000.00		1 Yes 2 X No
Aaryland 28a-f show d at once	Director	10e. Street and Number			10f. Zip Code		100	. Citizen of What	Country?
the M	吉	3426 Buckman Rd.	[‡] 202		22309		44	USA	
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland to Thealth and Mental Hygene. t: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner, must be notified at once.	- L	11. Marital Status 1 Never Married 2 X Married	12. Was Decedent Ever in U.S Armed Forces?		as Decedent of His res, specify Cuban		Specify Yes or No- rto Rican, etc.)	14. Race - A White, e	American Indian, Black, etc.
ter de	ш	3 Widowed 4 Divorced	1 X Yes 2 9 8 7 1	1	Yes 2 X No	specify:		Specify:	Black
urs af	db	15. Decedent's Education (Specify onl	y highest grade completed)	16a. Decede	nt's Usual Occupat	ion (Give kind		16b. Kind of Busin	iess/Industry
72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	ū			· ·		
0036 vithin ene.	틹	12th		Main	tenance '		ame (First, Middle, M		od Mgmt.
D 2/215-0036 should be filed within 72 hours at and Mental Hygiene. 7 is marked other than "natural ratic event, the Medical Examin	ပို	17. Father's Name (First, Middle, Last) James Cullen Will:	ioma Sr				ine Hilli		
212 Ild be Menta narke	шI	19a. Informant's Name/Relationship (Ty		19b. Mailin	ng Address (Stree		or Rural Route Numb		State, Zip Code) :
MD 21215-0036 d 2 should be filed within 7 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medica	-	Dorothy Williams/		3426	Buckman	Rd. #2	02 Alexa	ndria, V	A. 22309
e, M l and 2 Health a item 2:	Ī	20a. Method of Disposition		ace of Dispo ematory or o	sition (Name of cer	metery,	Date	20c. Location - C	Sity or Town, State
nor ages ant of other		1 X Burial 2 Cremation 3 Donation 5 Other Specify:	Removal from State	•	Cemetery	,	8-25-2007	Washin	gton, DC
Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygener Important: If item 27 is marked other if injury or other transmatic event, the Med		21. Signature of Euneral Service Licens					al Home,		
Deg Fer in in		234 Part I. Enter the disease, or compl	iall	4	217 9th	St. N.W	. Washin	gton. DC	20011
Physician		23a Part I. Enter the disease, or complifailure. List only one cause on each	cations that caused the death. I th line.	Do not enter	the mode of dying,	such as cardia	ac or respiratory arre	st, snock, ornean	Approximate Interval Between Onset and Death
/Medical xaminer	1		Her in and methado		oxication		1		Death
٠		or condition resulting in death) b.	Due to (or as a consequence of)	:					
	ě	if any, leading to immediate	Due to (or as a consequence of)	:	1	100			5.1
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of)						
ted ansit		events resulting in death) Last d.	Due to (or as a consequence or)						
760, icate be executed s physician and the burial - transit	Medical	X UNPENDED	AMENDED #23a 27.28a-f. no	erME.g8	71. 9/4/07	TT			
760, icate by physic the bun	Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregn	ancy				23d. Date of d	elivery Day Year
68° certifi nding	/sician/	past 12 months?	Live birth Pregnant at time of deal	4h =	etal death 3 Other (Specify)	Ectopic pre	sgriancy	Wichter	bay roui
Box e death c the atten ed for us	ysic	1 Yes 2 No 9 Unknown	9 Unknown	٠ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ	offier (opeony)				
. £ >.£	/ Phy	Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying cause	given in Part I.			ute to the cause of death?
, P.O	d by						- 1		Probably 4 V Unknown
ords, w requir us been s should!	Completed						24a. Was a autop	sy pr	ere autopsy findings available ior to completion of cause of
Reco The law cate has	mc d	4					perfor 1 Y Yes		eath? ✔ Yes 2 No
	BeC	25. Was case referred to medical			26.Plac	e of Death (Ch	eck only one)		
Division of Vital Records, tal or Attending Physician: The law required and the death. After this certificate has been sited in by the funeral director, page 2 should be a second to be a	To B	examiner?	ospital: 1 Inpatient 2				5,5,1,5	Residence 6	Other:
1 of Ving Ph		27. Manner of Death 1 Natural 5 Panding	28a. Date of Injury (Month, Day, Year)	28b. Time o		ury at Work?		now injury occurre	ď
ion ttendi death ctor: y the f	atio	1 Natural 5 Pending 2 Accident Investigation		Fnd 12:	SO pm	Yes 2 X No		Circuit and Numbo	r or Rural Route Number, City
Division pital or Attene ours after death teral Director: filled in by the	ertification:	3 Suicide 6 X Could not determined				building, etc.	or Town, S	itate)	ve. Baltimore, MD
in i	O	4 Homicide	an: To the best of my knowledge	1 stree		tate and place			
To the Hos within 24 h To the Fur	edical	(Check only 1 Certifying Physici one) 2 ✓ Medical Examiner	:On the basis of examination ar	nd/or investio	ation, in my opinio	n, death occur	red at the time, date	and place, and du	ue to the cause(s)
To the within To the comple	Med	29b. Signature and title of certifier	and manner stated.			se number			d (Month, Day, Year)
		(and	40 10a.	~	0.0	.M.E.		August 16,	2007
^		30. Name and address of person who	completed cause of death (Item	23a)					
K			nt Medical Examiner	111 Penr	Street, Baltin	nore, MD 2	1201		
		31. Date filed (Month, Day Year)	32. Registrar's Signatu	re					
Regis	trar	AUG 2 8 2007	arend D. Mir						

			1 - State Registrar	otate of wa	ai yiai k	Се	ertificate of	Death	u wentar		. No.	0 /	28068
•	Physici	an	Decedent's Name (First, Middle, La	st)					2. Date of Month	Death	Day	Year	3. Time of Death
	/Medic			ne B. Will	iams				Augu	ıst	18 2	007	3:15 P ^M
	Examin	er	4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o	or Location of D	Death		4c. County	of Death	
			Shangri-la Assis					ott Cit			How		
	Funeral Director		5. Social Security Number 6. S 408 20 7094	I⊓M 2√27F	e <i>(I</i> n <i>yrs. la</i>	as <i>t birthday</i> Yrs.	If Under 1 Year Months Days		Min. (Month,		ear) 1917		place (State or Foreign otry)
			Usual Residence of Decedent		U				June	23,	1917	Tem	nessee
	ylanı ylanı at		10a. State 10b. County		10c. City	, Town or L	ocation					1	0d. Inside City Limits
	Mar a-f sl	ģ	MD Howard		E3	licot	t City						1 ☐ Yes 21 No
	n the	ire	10e. Street and Number				10f. Zip Code			10g	. Citizen of W	/hat Cour	ntry?
	h wit 23a c st be	a D	4475 Montgomery R	oad			21043	3			Unite	d Sta	ates
	deat	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	3. 13.	Was Decedent of I If Yes, specify Cub		? (Specify Yes or	No-	14. Race	- Americ	an Indian,
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The marked other than "natural" or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Midowed 4 ☐ Divorced	1 Yes 2 X	No		1 ☐ Yes 2 🔀 No		ruento mican, etc.)		Specify	k, White,	
5-0	72 hou "natura dical E	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Dece	edent's Usual Occu e kind of work done DO NOT use retire	oation during most of	working	16	b. Kind of Bu		
727	filed within Hygiene. other than ent, the Me	Completed by	Elementary/Secondary (0-12)	College (1-4or 5	i+)		DO NOT use retire Omemaker	d)	J		Own Ho	me.	
ב	filed Hyg other ent,	e C	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Mid				
<u> </u>	2 should be filed and Mental Hygi Is marked other aumatic event, I	To Be	Luther A. Bazley					Allie :	Alsup				
2	should and Men marke	-	19a. Informant's Name/Relationship (Type. Print)		19b. Mail	ing Address (Street			mber. C	ity or Town.	State. Zio	Code)
2	nd 2 Ilth a 27 is r trau		Candace Harrison/I	Daughter			Orchard						
g.	is 1 and 2 of Health a item 27 is		20a. Method of Disposition		20b. Pla		osition (Name of ematory or other pla		Date	_	c. Location -		
Baltimore. Marvland 21215-0036	permit. Pages Department of I Important: If ite any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Specil</i>	y)		umbia	Memorial	Pk 8	-23-2007	- 1	larksv:	•	
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licer	- Willy	M010	44 2	2. Name and Address 112 01d (ess of Facility]	Harry H. a Pike E	Wit	zke's	Fami	lly FH Inc.
	-		23a. Part1. Enter the disease, or com	plications that caused	the death.							LLY	Annroximate
	Physician		shock, or heart failure. List only Immediate Cause (Final		ne.	,	renol	F	ilune				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as			/ - / - /	1 4	13/4			-	3 MONTH
	Examiner				ertens								20 years
	ji n	ē	Sequentially list conditions, if any leading to immediate	b. Due to (or as:								-	zo years
3	uted J ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	_									
oury 8760.	rificate be executed ng physician and as the burial-transit	Exa	resulting in death) Last	Due to (or as	a conseque	ence of):							
792	e be /sicia e bur			⊾d.									
Hours 68760.	ifficat g phy as th	Medical											
Č	n cert	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date	e of delive	rv
4 9	w requires that the death cer been signed by the attendir should be detached for use	Physician/	in the past 12 months? 1 ☐ Yes 2 ██No	1□Live birth 4□Pregnant at			⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		_	Mor		Day Year
60	t the	hys	9 □ Unknown	9□Unknown									
3 "	s tha	ру Р	Part II. Other significant conditions of	ontributing to death bu	ut not resul	ting in the u	inderlying cause giv	en in Part I.	23e. D	id tobac	co use contri	bute to th	e cause of death?
ő	quire n sig ald b								_ 1	☐ Yes	2□ No	3 ☐ Prob	ably 4 ∰Unknown
ဝ	w re	Completed							24a, W	as an	24h V	Vere autor	psy findings available
Be	he la e has	m							— aı	utopsy erforme	g l	rior to cor eath?	npletion of cause of
ta	ificat		25. Was case referred to medical					00 Di	1□ Ye		No 1	□Yes	2 No
5	Attending Physician: r death. ector: After this certifica by the funeral director, t	Be Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 🗆 E	R/Outpatio	nt 3□ DOA Oth		Death (Check on				
Ö	Phys er this eral dir	<u>ا</u>	27. Manner of Death	28a. Date of Injur	ry :	28b. Time o	III OLI DOA	4 LI NUISII			e 6XJOthe		asstd. lv
Division or Vital Records.	ding I th. : After : funer	įį	1 Natural 5 Pending 2 Accident investigation	(Month, Day	(Year)	Injury	1	k? Yes 2 ⊡ No			,,		
isi	or Attencafter death	lica	3 Suicide 6 Could not be	28e. Place of inju	Iry - At hon	ne, farm, st	reet, factory, office		28f. Location	n <i>(Str</i> ee	t and Numbe	r or Bura	I Route Number,
<u>i</u>	after after Dire	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)				City or	Town, S	State)		, , , , , , , , , , , , , , , , , , , ,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		(Check only 2 Medical Exar	ysician: To the best on niner: On the basis of	examination	ledge, deat on and/or ir	th occurred at the ti	me, date and p	lace, and due to to	he caus	se(s) and mai	nner as st	ated.
	To the I	Medical	29b. Signature and title of certifier	and manner sta	ited.		29c. Licens			-	Date signed		
			DMC 5_	m	1~	tern	it D	376	(3	7\	ugust	20	2007
	100		30. Name and address of person who	completed cause of de	eath (Item 2	23a) (Type	7 ,			A	ugust	20,	2001
1	100		P 0		,		e Patuxen	t Pkwv	Ste 205	Co1	umbia.	MD	21044
	Sta		31. Date filed (Month, Day, Year)	32. Relistra	ar's Signatu	ıre	_						
	Registra	ar	AUG 2 0 2	2007 Alexander	100	y. 1	backs						

			For Stata Registrar	State of Maryland			f Health a	nd Mental I	lygiene	2007	28069	
	9					uncate (or Death	2. Date of	Death		3. Time of Death	
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Marguerile	H. Whil	len			Month	ust 1	3 200°	7 8.30 AM	
	Examin		4a. Facility Name (If not institution, give s	street and number)			n, or Location of		1	County of Death	1	
			Ellicott City Nurs 5. Social Security Number 6. Sex		st hirthday)		ott City			loward 9. Birth	nplace (State or Foreign	
	Funeral Director]м аДГ 84	Yrs.		ays Hours	Min. (Month.	Birth <i>Day</i> , <i>Year)</i> 30 . 19	Col	nesota	
	ס	Usual Residence of Decedent									10d. Inside City Limits	
	Aaryla I shov	ō									1 ☐ Yes 3€ No	
	the N	rect	MD Howard 10e. Street and Number	<u>EI.</u>	licott	10f. Zip Cod	de		10g. Citi:	zen of What Co	untry?	
	h with 23a or	a D	3702 St. John's La	ane		210	42		U	SA		
	r deal	Funeral Director	Tr. Mantar States	12. Was Decedent Ever in U.S Armed Forces?	6. 13.	Was Decedent f Yes, specify (of Hispanic Orig Cuban, Mexican	in? (Specify Yes of Puerto Rican, etc.	No-	 Race - Amer Black, White 		
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 TNo If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀	No Specify:			Specify: W	hite	
9-0	d within 72 hours after death with the Maryland jien. I then "natural", or Itams 23a or 28a-f show Ite Mazileal Examinet must be notified at	ted	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Or	ccupation one during most	of working	16b. Kir	nd of Business/I	ndustry	
21	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	etired)	or norming				
72	T		12 17. Father's Name (First, Middle, Last)	1	HC	memake		r's Name (First, Mid		wn_Home Sumame)	<u> </u>	
land	e d la	To Be	C.J. Nachtigal					Volke Be	hrens			
Maryland 21215-0036	and and sum	-	19a. Informant's Name/Relationship (Ty					r or Rural Route Nu				
	s 1 and 2 if Health itam 27 i		Katherine L. Mall 20a. Method of Disposition					Catonsv		MD 212 cation - City or		
Baltimore,	Se jo		1X Burial 2 ☐ Cremation 3 ☐ R	removal from State		sition (Name of natory or other		8/18/2007			50	
altin	permit. Page Department i Important: If any Injury or once.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Sergles □ Gens	1404 440	22	2. Name and A	ddress of Facility	Harry H.	Witzk	e's Fam	ily FH Inc.	
ã	permit. Departr Importa any Inji		Mari Ella	les	41	12 01d	Columb:	ia Pk. E	llicot			
г	Physician /Medical		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ne cause on each line.			_		-		Approximate Interval Between Onset and Death	
			Immediate Cause (Final disease or condition resulting in death)	MIT	ral	Valu	e L	ndo co	vc uh	1		
1	Examiner			Due to (or as a consequence Deep Ver	ence or):	Throm	busis	3 Lec	1			
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	h 1:	to bro	210						
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ		001)	war	Z173				
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68											-777771157	
Вох	ath cer ttendir or use	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregn			2	23d. Date of del	ivery Day Year	
0.	at the dea by the a tached f	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	atn 5L	Other (specif	(y)					
<u>α</u>	es that I igned by be deta	by Ph	Part II. Other significant conditions cor	ntributing to death but not resu	iting in the u	nderlying caus	e given in Part I.	23e. í	oid tobacco u	use contribute to the cause of death?		
rds	w require been sig should b	ted to						_	☐ Yes 2[□No 3□Pr	obably 4 Minknown	
Records,	a S C	Completed						8	Vas an utopsy erformed?	24b. Were au prior to death?	re autopsy findings available r to completion of cause of	
alF			05.111				00 81	1□ Y	s 217No	1 ☐ Yes	21 No	
Vital	Physician: this certifica ral director, i	To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatier	nt 3 DOA	Other	of Death (Check o		6 ☐Other (Spe	cify)	
n of	<u>a</u> = e		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		Injury at Work?	28d. Descr	ibe how injur	y occurred		
Sio	Attanding ir death. ector: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be	One Place of laive. At he	forit	M	1 Yes 2 !		on (Street an	d Number or Ri	ıral Route Number,	
Division	or Attancater death Director:	Certification:	4 Homicide determined	building, etc. (Specify,							, a, , , , , , , , , , , , , , , , , ,	
	To the Hospital or Attand within 24 hours after death To the Funaral Director: completely filled in by the	edicai C	29a. Certifier 1 Certifying Phy. (Check only one) Medical Exami	sician: To the best of my knowner: On the basis of examinati and manner stated.	vledge, deat ion and/or in	h occurred at to vestigation, in	he time, date an my opinion, dea	d place, and due to th occurred at the ti	the cause(s) me, date and	and manner as place, and due	stated. to the cause(s)	
	To the within To the comple	Med	29b. Signature and title of certifier			29c. Li	icense number		29d. Dat	e signed (Monta	h, Day, Year)	
	0 -		> 60 ann			P3	30641		HU	gust 1	5 200 T	
_	<u></u>		30 Name and address of person who of Ramcels Tak	sapa/mi	261	Print) - 105	Rack	RIVESA	eck	Road	5 200 7 Balling Mal	
•	Sta Regist		31. Date filed (Month, Day, Year) AUG 1 7 2	32. Rynstrar's Signat	J.	berte						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23a Pt 1,25 per me 871,09/14/0/dhb Reg. No. For A State Registrar 28070 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Naro August orence 13 12:42 M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memoria Euston Talbo. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Ye Nov. 14, **Funeral** 6 Sex Age (In vrs. last birthday Birthplace (State or Foreign Country) Year) - 1919 219-30-1104 1 □ M 87 Yrs Director MD Usual Residence of Decedent la or 28a-f show t be notified at 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Director Pasadena 1 ☐Yes 2XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or? ; or items 23a c aminer must be 107 W. Hamburg Street 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 🔀 No Completed by Specify Specify: 3 XWidowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturany Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker **Home** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest Sappington Florence Rieggle 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Ward/Son 218 Johnny Lane, Stevensville, MD 21666 Date 17 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aug. 2007 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD Name and Address of Facility Irranco & Sons, P.A. Severna Park Funeral Home 5 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service License 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) crania Due to (or as a consequence of): Probable Hypertensive Infarct Sequentially list conditions, CERTIFICATION APPROVED BY MEDICAL EXAMINER in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence on): Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 🗷 No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2X No 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes ≥ No

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Certification:

ဥ

27. Manner of Death

1 X Natural

3 Suicide

29a. Certifier

2 Accident

4 ☐ Homicide

signed by the attending physician

The law requires that the death certificate be executed To the Hospital or Attending Physician: Director: After this filled in by the funeral

Box

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Records,

Division or Vital

within 24 hours a To the Funeral D Medical State

DHMH 17 Rev 1/2001

Registrar

1 Inpatient

28a. Date of Injury (Month, Day Year)

MD

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

Iniury

29c. License number

Washington

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

(Scatifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

219 Abraham Janiel

31. Date filed (Month, Day,

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

AUG 1 5 2007

Physician /Medical Examiner The law requires that the death certificate be executed physician ar s the burial-ti Box 68760 as attending p signed by the a Records. been signature

Physician

/Medical

Examiner

Funeral

Director

28a-f show

iral", or items 23a or 28a-f shov Examiner must be notified at

23a

or items

"natural"

d other than "natu event, the Medical

Department of H Important: If ite any Injury or of once.

f Health and Mental Hygiene. Item 27 Is marked other thar

Director

Funeral

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Completed

Be

2

the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examine Physician/Medical Completed by e 2 r this certificate has funeral

To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; At completely filled in by the fu IUA nfs State

Division or Vital

or Attending Physician;

After

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FFMALE 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical Medical Certification: To Be 27. Manner of Death 5 Pending investigation (Month, Day Year) Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 10062929 August 4 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Memorial of Emmander 25 Bosmost Cumber Lond, M EMMANUEL DIET BORMAH

Avenue

165

Registra

07-06585 Ivy Jane Zola Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Jane Zola	1-	State of Maryland / Department of Health and Merital Fig. 5 Certificate of Death	Reg.	No. 201	7 2807					
Physician	Re	edistrar Decedent's Name (First, Middle,Last)	2 Date of Death		3. Time of Death 0702 hrs					
edical Examine	er I	vy Jane Zo1a Solid New (first institution give street and number) 4b. City, Town, or Location of Death	Month August 25, 2	4c. County of Death						
	4:	a. Facility Name (if not institution, give street and number) 9427 Lost Trail Way 4b. City, Town, or Location of Death Potomac		Montgomery						
Funeral	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs		MM/DD/YYYY) 9. Bir Foreig	thplace (State or					
Director	2	219-19-1668 1 M 2 X F 22 Yrs. Months Days Hours Min	June 1	9, 1985 ^{co}	untryWash DC					
	_	Isual Residence of Decedent 10c. City. Town or Location			10d. Inside City Limits					
ow an		MD Montgomery Potomac			1 X Yes 2 No					
Sa-f sh	Director	Oe. Street and Number 10f. Zip Code	. 10g	. Citizen of What Cou	1					
with the Maryland ns 23a or 28a-f show any be notified at once.	Öİ	9427 Lost Trail Way 20854		United St	ican Indian, Black,					
death with the Maryland or items 23a or 28a-f sho	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No- o Rican, etc.)	White, etc.	Ican Indian, Blass					
er deatl		1 Ves 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:			ite					
hours afte "natural" Examine	-\و	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use re		6b. Kind of Business	Industry					
136 hin 72 ho e. than "na edical Ex	lete	Elementary/Secondary (0-12) College (1-4 or 5+) 3 Student		Educatio	on					
5-0036 led within 72 Tygiene. other than '	Completed		ne (First, Middle, Ma	aiden Surname)						
21215-0036 Uld be filed within 7 Mental Hygiene, marked other than	e l	Geoffrey Zola	Cohen	on City or Town Stat	e Zin Code)					
	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of 9427 Lost Trail Way I	Potomac M	D 20854	0, Zip 0500)					
, MD and 2 sho ealth and em 27 is traumat		Geoffrey Zola - Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City of	r Town, State					
nore iges 1 ant of 11 tt: If it		The remainded of Disposition 3 Removal from State Carden of Remembrance 8,	/28/07	Clarksbur	g, MD					
Baltimore, permit. Pages I a Department of He Important: If ite	H	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21. Rockville	gal Direc	tion Inc	20852					
166		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			Approximate Interval					
Physician // // // // // // // // // // // // //		failure. List only one cause on each line.			Between Onset and Death					
caminer	1	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):								
		Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):								
	nine	cause. Enter Underlying Cause								
ed asit	Exar	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.								
60, e be executed ysician and burial - transit	edical Examiner	X UNPENDED 4MENDED 7,28a-f. perME,g871, 9/20/07 tT								
'60, cate be physici he buri	Med	IF FEMALE: 23c. If yes, outcome of pregnancy	anancv	23d. Date of deliv Month	ery Day Year					
OX 6876(eath certificate attending phy	sician/M	past 12 months? 4 Pregnant at time of death 5 Other (Specify)								
Box 6876 e death certificate the attending physical for use as the	Physi	1 Yes 2 No 9 V Unknown 9 Unknown	23e. Did to	bacco use contribute	to the cause of death?					
D.O. that the ned by detach	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Yes		robably 4 Unknown					
lS, F quires en sign uld be	ted		24a. Was		autopsy findings available to completion of cause of					
COrc law re has be	Completed		perfo	rmed? death 2 ✓ No 1	? Yes 2 No					
Re(: The tificate or, page		1 25 was case referred to medical	eck only one)							
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	o Be	examiner? Hospital: Inpatient 2 ER/Outpatient 3 DOA Other No.	ursing Home 5	Residence 6 0	ther: Scene unk					
of ing Ph	Ä.	27. Manner of Death Tn(Month, Day, Year) 1 Yes 2 No	l l	now injury boodings						
Sion Vttend death. ector:	catic	2 Accident Investigation 8/25/2007 F1Id 7:00 diff 1 28e Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number of	Rural Route Number, City					
Divis	Certification:	Suicide determined (Specify) Found; Home			Way Potomac, MD					
Hospi 24 hou Funer tely fil		29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, if they control and manner stated. 29c. License number		29d. Date signed	(Month, Day,Year)					
	Σ	29b. Signature and title of certifier O.C.M.E.		August 26, 20	007					
		30. Name and address of person who completed cause of death (Item 23a)								
		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baitin	more, MD 2120)1						
	state									
Regi	sıпа									

Registrar

State

old Frederic Rd. #18. Baltmore, Moderag

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

07-06432 John Bentzen Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

John Benzen		1- For State Registrar		oi Maryiano		ificate of De		nd Mental		Reg. No. 2	00	7 2807
Physicia Medical Exami		1. Decedent's Nan John Bent	ne (First, Middle,Last zen)				ktanta*star	. 2. Date of De Month August 1		'ear	3. Time of Death 1827 hrs
بغير			(if not institution, give	street and number)	4b. C	ty, Town, c	or Location of De			ty of Death	1027 1115
		2805 Erdm					Itimore					
Funeral Director		5. Social Security 215-17-59 Usual Residence of	62 ¹ XX	x 7. A(ge (In yrs. las		Under 1 Ye		din. Jan 20		Foreign	nplace (State or n Intry) MD
any		10a. State	10b. County		10c. City, T	own or Location	wn or Location					10d. Inside City Limits
death with the Maryland or items 23a or 28a-f show must be notified at once.	tor	MD	Anne Aruno	de1	Pasad							1 Yes 2 No
Maryla or 28a-f)irec	10e. Street and Nu				10f.	Zip Code			10g. Citizen of \	What Count	iry?
with the Mark 13a or 23a or 25e notified	ral	4401 Fors 11. Marital Status	ythia Ln	12. Was Deceden		13. Was Dec	21122 Decedent of Hispanic Origin? (Specify Yes or N			USA 0- 14. Ra		an Indian, Black,
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	Funeral Director		ied 2XX Married	Armed Forces 1 Yes 2	? XX No			an, Mexican, Pue	rto Rican, etc.)		nite, etc.	
ural", miner	by	3 Widowed	4 Divorced ducation (Specify on	If Yes, Give Year or Dates:		1 Yes			of work done	Specify	MILLI	
72 hounuat	Completed	Elementary/Sec		College (1-4 or		during most of	working life	e. DO NOT use r	etired)	16b. Kind of I	dusiness/in	dustry
0036 within jene.	duc	12		1		Utility	Locat			Utilia		
21215-0036 suld be filed within 7 Mental Hygiene. marked other than c event, the Medica	æ		(First, Middle, Last) ntzen, Sr.					18.Mother's Na Ann Qu	me (First, Middle, ueen	Maiden Surnan	1e)	/
MD 21 nd 2 should alth and Me m 27 is ma aumatic ev	은	19a. Informant's Na Angela M.	ame/Relationship (Ty	vpe, Print) Wife		19b. Mailing Add					wn, State,	Zip Code)
e, M I and 2 Health Item 2		20a. Method of Dis	sposition			ace of Disposition (Name of ce	_	Date Date	20c. Location	n - City or T	own, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		4 Donation 5	Cremation 3 Other Specify:			matory or other pla on Park Cer		Aug	23, 2007	Baltimo	re, MD	ı
Bali permit Depart Impor Injury		Grego	7 \ /\	MON		426	Crain I		len Burnie			
Physician /Medical		23a. Kart I. Enter ti fature. List or	ne disease, or compli nly one cause on eac	cations that caused th line.	the death. D	o not enter the mo	de of dying	, such as cardia	or respiratory ar	rest, shock, or h	eart	Approximate Interval Between Onset and
Examiner	Ì	Immediat Cause or condition resulti		Cocaine and		<u>intoxicat</u>	ion					Death
		Sequentially list co	onditions, b									
	Examiner	if any, leading to in cause. Enter Unid. (Disease or injury)	urlying Causa	oue to (or as a cons	equence of):							
nd uted		events resulting in		ue to (or as a cons	equence of):							
760, care beexecuted physician and the burial - transit	Medical	X UNPENDED		##ENDED #23a,27,28	a-f, per	ME, G871,	9/5/07	TT				
\$876 rtificat fing phy		IF FEMALE: 23b. Was decedent past 12 months		23c. If yes, outcor	ne of pregnar	ncy 2 Fetal dea			nancy	23d. Date of Month	of delivery Da	ay Year
Division of Vital Records, P.O. Box 687 tal or Attending Physician: The law requires that the death certific irs after death. "I Director: After this certificate has been signed by the attending I led in by the funeral director, page 2 should be detached for use as the content of the conte	Physician/		No 9 Unknown	4 Pregnant at 9 Unknown	time of death	5 Other (S	ipecify)					
P.O. s that the med by (detache	<u>a</u>	Part II. Other signi	ificant conditions	contributing to deat	h but not resu	alting in the underly	ring cause	given in Part I.	23e. Did t			ne cause of death?
rds, require been sig	eted	-					<u> </u>		- 24a. Was	to the track		opsy findings available
ecol he law ste has l	Completed			 .					autor perfo	rmed?	death?	mpletion of cause of
al R ian: T certifica ctor, pa	Be C	25. Was case refer	<u> </u>				26.Place	e of Death (Chec		2N0	1 Yes	2 No
F Vit	[일		2 No	ospital: 1 Inpatie		R/Outpatient 3	DOA		sing Home 5	Residence 6		Scene
on on on on on on on on on on on on on o	Ë	27. Manner of Deat 1 Natural	5 Pending	28a. Date of Inju (Month, Day,Y	ear)	3b. Time of Injury		ry at Work? Yes 2 X No	28d. Describe unk	how injury occu	rred	
visic r Atte ter dea lirecto	licat	2 Accident 3 Suicide	Investigation 6 X Could not be	00 - Di		nd 6:25 pm e, farm, street, fact			28f. Location (Street and Num	ber or Rura	al Route Number, City
Diversal cours at filled i	Certification:	4 Homicide	determined		ound in	dwelling			2805 Erdr	otate) nan Ave.	Baltim:	ore, MD
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate beexecuted within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier 1 (Check only one) 2	Certifying Physicia Medical Examiner:	n: To the best of my On the basis of examend manner stated.	y knowledge, mination and/	death occurred at or investigation, in	the time, do	ate and place, ar n, death occurred	nd due to the caus I at the time, date	se(s) and manne and place, and	er as stated due to the	cause(s)
F 2 4 8	ŝ	29b. Signature and		and manner stated.			29c. Licens	se number		29d. Date sig	ned (Month	ગ, Day, Year)
		A.	1 20,	mod			O.C.	M.E.		August 20	, 2007	
0		30. Name and addr Ling Li, MD	ess of person who co Assistant Me	mpleted cause of dical Examine	,	^{a)} enn Street, Ba	ltimore	MD 21201				
Sta		31. Date filed (Mont	th, Day, Year)	32 Registra	's Signature	Sparke						
Regist	rar	SE	P @ 4 2007	J. Marchael	1 July 1	100						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 30 07 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, dive street and r Examiner Ming If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 XM 2 ☐ F Yrs. 87 Director 226-16-9863 FEB. 21, 1920 VIRGINIA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director BALTIMORE MARYLAND N/A death with the 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 5914 STARLEIGHT RD. 21206 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. and 2 should be filed within 72 hours after 1 X Yes 2 No If Yes, Give Year or Dates: 42/45 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: BLACK 3 Widowed 4 □ Divorced 'natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LONG SHOREMAN PRIVATE 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROBERT BLANCHARD DAISY BLANCHARD ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any Injury or other trai 5914 Starleigh Rd., Baltimore, Maryland 21206 Anna Maisonet/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 09-07-07 OWINGS MILLS, MARYLAND GARRISON FOREST 21. Signature of Fune al 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE 23a. Part I the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician nor oral intake disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner rneumania Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner fibrillation Atrial The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached t 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 ☐Unknown 1 ☐ Yes 25. Was case referred to medical examine? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 21 No certificate 1□ Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:

A Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 🗌 Yes 2 ∏ No I Director: A 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours aft

To the Funeral D

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier H0064267 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 827 Linden Av. Baltimore ousins = 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 26 2007 /Medical Evelyn Bushrod August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Health Howard & Rehab Fllicott If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ Days Months Hours Min 213-26-9467 Director 2-6-1933 Μđ Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Md. 1√Yes 2 No Funeral Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 E. 20th Street 21218 USA 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2√□ No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Disabled NΑ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sylvester Easy မ Odessa Tolbert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Coleman 6005 Huntclub Lane, Baltimore, Md. Disposition (Name of Date 20c. Location - City or Town, State Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Mem. Pk. 9-1-07 Randallstown, 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility March F/H East waren East North Ave, Baltimore, Md 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician FEVER /Medical Due to (or as a consequence of) Examiner SPIRATOR DISTRESS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner AND ASPIRATIONI PNEUMONIA and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 2 - No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed After t death. within 24 hours after death To the Funeral Director:

Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print) Merre

6 Could not be determined

3 Suicide

29a. Certifier

Medical

State

4 Homicide

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Smith Auc

2835

32. Régistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

BA, MD 21209

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

August 28, 2007

			State of Maryland / Department of Heal 1- State Amend 20a-c,22, perfh, 2875, 1/16/08 TI Certificate of Dea	Lett 1	g. Nome of the
	Physici /Medi		1. Decedent's Name (First, Middle, Last) AUM ART	2. Date of Death Month.	24 2007 2AM M
	Examir Funeral Director	er		Inder 24 Hrs. 8. Date of Birth	Year) 948 9 Birthplace (State or Foreign Country) Pennsylvania
land	MC TI		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Mary	a-f sho	ctor	MD Baltimore		1 √ Yes 2 □ No
vith the	or 28 Se no	Director	10e. Street and Number 10f. Zip Code 2120		Og. Citizen of What Country? USA
72 hours after death with the Maryland	ral', or items 23a or 28a-f show Examiner must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married Mar	nic Origin? (Specify Yes or No- exican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:White
ed within 72 hours af	9 2	Completed b	3 ☐ Widowed 4 ☑ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	g most of working	16b. Kind of Business/Industry un
filled wit	E + 3		8 0 fork lift trucke		Anido a Cumama l
ill be fil	d d) Be		Mother's Name <i>(First, Middl</i> e, M Tosephine Morga:	
nd 2 shou	27 Is m	2	19a. Informant's Name/Relationship (Type, Print) Josephine Knight/sister 19b. Mailing Address (Street and No. 19b. Maili	Number or Rural Route Number,	City or Town, State, Zip Code)
permit. Pages 1 ar	0 = 5		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)	Sant 14 2007	20c. Location - City or Town, State Baltimore, MD
Dermit.			21. Signature of Funeral S. rue elicensee S. Wade, Virector Baltimore,	Brandley Ashto	n F.H. 2134 Willow Spring Paltimore Street more, MD 21222
recuted III	physician and Medical xaminer transit transit	Examiner	23a. Part. Finier the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	A - A	sst, Approximate Interval Between Onset and Death
The law requires that the death certificate be so		Physician/Medical	d		23d. Date of delivery Month Day Year
onires tha	been signed k should be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in		pacco use contribute to the cause of death? as 2 □ No 3 □ Probably 4 ☑ □ Know
		Completed		24a. Was ar autops perform 1 Yes 2	y prior to completion of cause of
Physician:	certificate irector, pag	o Be	examiner? Hospital:	Place of Death (Check only only only ursing Home 5 Reside	
	After	H-	27. Mann, of Death 1 atural 5 Pending (Month, Day Year) 28b. Time of Injury at Work? 2 Accident investigation	28d. Describe ho	w injury occurred
ō	E Sign	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town	·
To the Hospital	wi hin 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, do not be said of examination and/or investigation, in my opinion and manner stated.	n, death occurred at the time, da	ate and place, and due to the cause(s)
Tol	Tol	2	29b. Signature and title of certifier 29c. License nur 29c. License nur 30. Name and add ass of per none o completed cause of death (Item 23a) (Type, Print)	97690 2º	9d. Date signed (Month, Day, Year) August 24, 20
dr.	St.	210	30. Name and add is so of per in o completed cause of death (flem 23a) (Type, Print) LUAW 205 York 1 31. Date filed (Month, Day, Year) 32. Registrar's Signature	40 LUTHER	VILLE ,40 2109)
	Regist		SEP 0 4 2007		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year 1300 M Herman Stewart Buswell 2007 /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4215 Buffalo Road Mt. Airy Carroll 8. Date of Birth (Month, Day, Year) Feb. 17, 1936 5. Social Security Number 9. Birthplace (State or Foreign Country)
PA If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthdav) **Funeral** Months Days 205-28-1036 1 X M 2 T F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~- "any injury or other traumatic event." 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Carroll Mt. Airy 1 TYes 2X TXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4215 Buffalo Road 21771 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Xes 2 □ No 1955 – If Yes, Give Year or Dates: 1959 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Narried 1 ☐ Yes 2 🛛 No Specify Specify: 3 Widowed 4 Divorced 1959 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Engineer Dept. of the Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Stores Buswell Anna Garver 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4215 Buffalo Road Mt.Airy, MD Carol Buswell Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XXBurial 2 □Cremation 3 □Removal from State Prospect Ch Cemetery Sept. 5, 2007 Mt. Airy, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ²² Name and Address of Facility Burrier-Oueen Funeral Home & Crematory PA 1212 W. Old Liberty Road Winfield, MD 21784 Pint / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death med te Cause (Final **Physician** YPAVS THEVOSCIEN resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9∏Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No autops, performed, 2 No 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural (Month, Day Year) 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital 🛴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year)

6+1

State Registrar 31. Date filed (Month, Day, Year)

4 2007

32. Registrar's Signature

07-06569 Dwight N Baker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

wight in baker		1-For State of Maryland / Department of Health and M Registrar Certificate of Death		eg. No. 2007 2807						
Physicia	an/	Decedent's Name (First, Middle,Last)	2. Date of Dea	th 3. Time of Death						
Medical Exami	ner	Dwight Nathaniel Baker Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Local	Month August 25	6, 2007 0101 hrs						
		Sinai Hospital ER Baltimore								
Funeral Director		Months Days H	Ours Min	th(MM/DD/YYYY) 9. Birthplace (State or Foreign						
Director	n	225-96-8250 1 M 2 F 35 Yrs.	May,	27 1972 Country)VA						
	B. N. B. L.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits						
faryland 28a-f show 1 at once.	ō	MD Randallstown		1 Yes 2 No						
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What, Country?						
		8444 Allenswood rd 21133 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic		SA 14. Race - American Indian, Black,						
feath wi	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mex		White, etc.						
after c	by F	3 Widowed 4 Divorced If Yes, Give Year of Dates: 1 Yes 2 No specify: Specify: Black								
hours "natur	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (0 during most of working life. DO N		16b. Kind of Business/Industry						
5-0036 led within 72 Hygiene. other than "	Completed	12th Forklift opera	ator	Wharehouse						
		17. Father's Name (First, Middle, Last) 18.Mc	other's Name (First, Middle,	Maiden Surname)						
2121 2121 Mental Marked c event,	To Be	owner indefinited banes	ary Cotton Number or Rural Route Nur	nber, City or Town, State, Zip Code)						
₹ 2₽2 ⋜	1	Mary CottonMother 2219 Georgia								
ore, Nes 1 and of Health If item her trade		20a. Method of Disposition 20b. Place of Disposition (Name of cemeter crematory or other place) Removal from State		20c. Location - City or Town, State						
Fage Page them of or oth	io si ÷	4 Donation 5 Other Specify: Meadow Brook		Suffolk, VA						
Baltimore, permit, Pages I and Department of Heal Important: If item injury or other tra		21. Signature of Funeral Service Licensee 22. Name and Address of Fa W. Wesley Cl	navis III F	uneral Service Inc D Dunkirk, MD 20754						
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such	as cardiac or respiratory an	rest, shock, or heart Approximate Interval Between Onset and						
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot Wound of Chest and Drowning		Death Death						
		or condition resulting in death). Due to (or as a consequence of):								
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	٥. :							
1 -	Examiner	(C)isease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
Transi		d.								
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Medical	UNPENDED								
3876 rtificat ling ph		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Eco	ctopic pregnancy	23d. Date of delivery Month Day Year						
Box 687 s death certifice the attending p	Physician/	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)								
O. B at the d at the d tached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	in Part I. 23e. Did t	obacco use contribute to the cause of death?						
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cords aw requi- has been 2 should	plet		24a. Was	prior to completion of cause of						
tal Records cian: The law requi certificate has been ector, page 2 should	Completed		1 ✔ Yes	rmed? death? 2 No 1 ✔ Yes 2 No						
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the	BB	examiner? Hospital:	eath (Check only one) Nursing Home 5	Residence 6 Other:						
n of Vit ding Physic After this funeral dir	<u>د</u>	27 Manner of Death 28a Date of Injury 28b Time of Injury 22c Injury at N	Work? 28d. Describe	how injury occurred						
ion Itendir Icath. for: A	atio	1 Natural 5 Pending Pending Accident Investigation Aug 25, 2007 Pending	2 ✓ No Subject sho	ot and drowned						
Jivis Il or A after of Il Directed in by	Certification:	3 Suicide 6 Could not be determined (28e. Place of Injury - At home, farm, street, factory, office buildin	or Town.	Street and Number or Rural Route Number, City						
Lospitz 4 hours 7 unera		29a. Certifier	l'a.	t, Baltimore, MD						
Division of Vital Records, P.O. Box 68760, Voite Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deat and manner stated.								
F % F 8	ğ	29b Signature and title of certifier 29c. License num		29d. Date signed (Month, Day, Year)						
	Į	total Oronica-tollet in O.C.M.E.		August 25, 2007						
3		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street,	, Baltimore, MD 2120	1						
	~~~	31. Date filed (Month, Day, Year)								
Regist	rar	SEP 0 4 2007								

07-06491 Jewel B. Blacksi	neal	Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental Hy		ole.	
		1- For State Certificate of Death	Reg.	_{No.} 200	7 2808
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last)  Jewel Bernita Blackshear	Date of Death     Month Da     August 21, 2	ay Year	3. Time of Death 2108 hrs
,		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Deat	1
		Bowie Medical Center Bowie	1	Prince Georg	
Funeral Director		5. Social Security Number 6. Sex 1. Months Days Hours Min.	•	MM/DD/YYYY) 9. Bir 1954 Forei	Washington Washington Mashington Mashington
~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	**************************************	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
_ ·	or	MD Prince George's New Carrollton			1 XYes 2 No
for death with the Maryland I", or items 23a or 28a-f show our must be notified at once.	Director	10e. Street and Number 5544 Karen Elaine Drive #1525 10f. Zip Code 20784		Citizen of What Cou	ntry?
death with	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - Amer White, etc.	ican Indian, Black,
after o	þy F	3 Widowed 4 X Divorced If Yes, Give Year or Dates:		Specify: B1	
2 hour		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)		b. Kind of Business	missis to the Salara
036 vithin 7 ene. er than Medica	Completed	3 Disabled	4134	None	<b>!</b>
11215-0036 11215-0036 found Hygiene. narked other than "nate even, the Medical Exa	Be Co		(First, Middle, Maid e Hilda	,	
D 2121 should be fi and Mental 7 is marked	To B				e, Zip Code)
<b>∑</b> .2.4.2.€.		$\begin{array}{llllllllllllllllllllllllllllllllllll$	se Cour	t #227	
Baltimore, MD 2 permit Pages I and 2 shou Department of Headsh and N Important: If item 27 is n njurry or other traumatic		1 X Burial 2 Cremation Removal from State Lincoln Memorial 9/	1/2007 S	oc. Location - City of Suitland	Town, State  MD
Baltimo permit Page Department of Importanti	en i si	4 Donation 5 Other Specify: Cemetery 21 Signature of Juneral Service Ligensee 22. Name and Address of FacilityHen	ry S. W	ashingto	n & Sons
	_	to., Inc., 4925 Washington, DC 2  23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o	N H Bu	rrougns	Ave., N.E
Physician /Medical		failure. List only one cause of each line.  Immediate Cause (Final disease a. Hypertensive atherosclerotic cardiovascular d		STIDEN, OF FIERR	Between Onset and Death
Examiner	•	or condition resulting in death)  Due to (or as a consequence of):	ISCOSC		<del> </del>
	, í	Sequentially list conditions, b.  If any, leading to immediate Due to (or as a consequence of):			
	xaminer	cause. Enter Underlying Cause (Disease or injury that initiated experts resulting in death). Last experts resulting in death). Last experts resulting in death. Last experts resulting in death. Last experts resulting in death.	, t		-
nd cuted	W	events resulting in death) Last Due to (or as a consequence or):  d			
be execute	ian/Medical	Unpended #23a,PII,27,perME,g872, 10/15/07 TT			
876( ifficate ig phys	n/Me	IF FEMALE: 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancv	23d. Date of deliver Month	y Day Year
Box 68760, e death certificate by the attending physic ed for use as the bur	sicia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)			
by the riched for	Physici	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
P.O.	d b	Systemic lupus erythematosus	1 Yes	2 No 3 Pro	bably 4 Unknown
ords  v requi s been should	Completed	Mild Acute pneumonia with hyaline membranes	24a. Was an autopsy		utopsy findings available completion of cause of
RecC The lav	ome	Liver steatosis	performe		
tal Feiang certificector,	Be	25. Was case referred to medical examiner?			
ion of Vital Records, P.O. Box 68760, rending Physician: The law requires that the death certificate be executed. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - trans	<u>٩</u>	27. Manner of Death  28a. Date of Injury  28b. Time of Injury 28c. Injury at Work?	g Home 5 Res	sidence 6 Othe	r: 
	Certification:	1 X Natural 5 Pending (Month, Day,Year) 1 Yes 2 No			
Division tal or Attendi	tilicii	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Stre		ural Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the		4 Homicide determined (Specify)  29a. Certifier		<u> </u>	
To the He within 24 To the Fe completed	Medical	29a. Certifier (Check only one)  2 Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place one of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and other occurred at the basis of examination and occurred at the basis of the basis of examination and occurred at the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis			
To wii	Me	29b. Signature and title of certifier 29c.License number	29	9d. Date signed (Mo	nth, Day, Year)
<b>A</b>		O.C.M.E.		August 25, 2007	
OCM		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, M</li> </ol>	ID 21201		

Registrar

State 31. Date filed (Month, Day, Year) SEP 0 4 2007

32. Registrar's Signature

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:45 а. м Harold E. Brooks August 27, 2007 /Medical 4c. County of Death
Howard 4b. City, Town, or Location of Death Columbia 4a. Facility Name (If not institution, give street and number) Examiner 10101 Governor Warfield Parkway #114 Birthplace (State or Foreign County) If Under 1 Year | If Under 24 Hrs. Date of Birth 6. Sex 1 M 2 □ F 5. Social Security Number 217-26-7049 7. Age (In yrs. last birthday) **Funeral** (Manuary 12 1929 Months Days Hours Min. **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 'natural", or items 23a or 28a-f shov dical Examiner must be notified at Columbia 1 ☐ Yes 2 X No Maryland Howard Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21044 10101 Governor Warfield Parkway ₩\\ Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 □ Xes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1947 1 ☐ Yes 2 ☐**X**No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 1949 Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natuany injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired)

Electrical Engineer Engineering Elementary/Secandary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Gladys Blanche Gray 17. Father's Name (First, Middle, Last) Be Harold E. Brooks ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ms. Vickie Fletcher Catonsville 1613 Park Grove Mo 20c. Location - City or Town, State
Garrison Forest, Maryland 20b. Place of Disposition (Name of 20a, Method of Disposition Date cemetery, crematory or other place)
Maryland Veterans Cemetery 08/31/07 1 □ Surial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Home, P.A. 21. Signature of Funeral Service Licensee 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician 2 400-5 Obstructive Chronic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Luis to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 1 Pres 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe this certificate 2 No 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death Check onl one examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Injury 1. Natural 1 ☐ Yes 2 ☐ No s after death.

I Director: A
ed in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 724 Ciffle Potu xent )€ 100m 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

0 4 2007

Division or Vital Records, P.O. Box 68760.

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State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

0 4 Sinai

32 Registrar's Signature

29c. License number

Huspital of Baltimore

29d. Date signed (Month, Day, Year)

		1 = For State Registrar	State of Maryland		artment of H		lental Hygio	ene g. No. 2007	28084
Physici		1. Decedent's Name (First, Middle, Las	ybone				2. Date of Death Month August		3. Time of Death
/Medi Examir		4a. Facility Name (If not institution, give	<del></del>		• • • • • • • • • • • • • • • • • • • •	Location of Death	riagust	4c. County of Death	
		Northwest Ho	spital		Randall			Baltimor	
Funeral Director		5. Social Security Number 6. Se	x	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1)	Year) 9. Birthp	lace (State or Foreign
File objekt stransverke		Usual Residence of Decedent					.0 20-	110 1 / car	grana
arylan show d at	_	10a. State 10b. County		Town or Lo				1	0d. Inside City Limits 1 ☐Yes 2 ☐ No
the M 28a-f notifie	ecto	10e. Street and Number	/50	illim	10f. Zip Code		100	g. Citizen of What Coun	
3a or	i D		way St.		,	21230	10,	4.5.4	,
ems 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Nas Decedent of H	ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No-	14. Race - Americ Black, White,	
and 21215-0036  be filed within 72 hours after death with the Marylan ntal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 Mever Married 2 Married 3 Widowed 4 Divorced	1		1 □ Yes 2 <del>□</del> No			Specify: 13 10	/
2 hour	ed b	15. Decedent's Ed	ication	16a. Deced	dent's Usual Occup	ation	1 10	6b. Kind of Business/Ind	lustry
21215-0036 d within 72 hours af giene. er than "natural", or the Medical Exami	Completed	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5+)	(Give life. L	DO NOT use retired	during most of worki )	ing	// ///	
121 Hygier Hygier Her th		17. Father's Name (First, Middle, Last)	4	/	Nurse	18. Mother's Name	/First Middle M	Health	
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. T? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	To Be	$\alpha / \alpha /$	Norne			Bessi		Le v	
ary shoul and M	ř	19a. Informant's Name/Relationship (7		19b. Mailin	ng Address (Street a		al Route Number,	City or Town, State, Zip	Code)
'e, Ma 1 and 2 Health a tem 27 is		Jewel Green	sister	7120	7	sill Cf.	apt 1B	Baldo ly	21244
S = 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	metery, crer	sition (Name of natory or other place	re)		Oc. Location - City or To	wn, State
Baltimo		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License			A Cremeto,	of Fability	-2007	Balto, lu	PA
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		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. ne cause on each line.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between
Physician	Ĥ	Immediate Cause (Final disease or condition resulting in death)	a. AID	S					Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):					
	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequent	ence of):					
ind transit	Examiner	cause. Enter Underlying Cause (Uisease or injury that initiated events	c						
8760, cate be exected and hysician and the burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):					
687 ifficate g phys	edical		d						
box 6	M/ue	23b. was decedent pregnant	23c. If yes, outcome pf pregnar 1 □ Live birth 2 □ Fetal		Ectopic pregnancy			23d. Date of delive	,
P.O. BOX int the death cert is by the attending	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of de 9□Unknown		Other (specify)			Month	Day Year
that the ed by detacl		Part II. Other significant conditions co	ntributing to death but not resul	ting in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to the	e cause of death?
Records, P.O. The law requires that the dishers been signed by the age 2 should be detached	d b	seizures			···········		1 ☐ Yes	s 2 No 3 Prob	ably 4 Unknown
eco law re as bee 2 sho	Completed by	CNS lesion					24a. Was an autopsy		psy findings available inpletion of cause of
Or VITAL HE Physician: The lav this certificate has al director, page 2	Com						performe	ed? death? DNo 1 □ Yes	2 No
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OF Physer this eral dii	1: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of	t 3 DOA Our	4 □ Nursing Ho	me 5 Residen 28d. Describe how	ice 6 Other (Specify	/)
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pital o		29a. Certifier 1 Certifying Phy	sician: To the best of my know	ledge death	occurred at the tin	ne date and place	and due to the car	use(s) and manner as of	ated
To the Hospital or Attending Physician: The law requires that the death certificate be expected within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical		iner: On the basis of examinati and manner stated.						
To th Vithin To th Comp	Me	29b. Signature and title of certifier	<u> </u>		29c. License		290	d. Date signed (Month,	Day, Year)
•			MO			66171	P	tugust 30	2007
2		30. Name and addless of person who o		23a) (Type, I	Print)				
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	Physici /Medi		Decedent's Name (First, Middle, Last)  John A. Crayford				2. Date of Death Month	9431 2007	3. Time of Death	
	Examir Funeral Director	ner	4a Facility Name (If not institution, give street and number 5. Social Security Number 6. Sex 112M 2 F	Age (In yrs. last birt	D Bell	or Location of Death	8. Date of Birth 05/22/192	9. Birthple County	ace (State or Foreign	
	Maryland -f show	tor	Usual Residence of Decedent  10a. Slate 10b. County  Maryland Harford County	10c. City, Towr				10	od. Inside City Limits 1 ☐ Yes 2 No	
	h with the 3a or 28a st be noti	al Director	10e. Street and Number 1305 Beautont Court		10f. Zip Code 21050			Citizen of What Country?		
980	hours after death with the Maryland turst', or Itsms 23a or 28a-f show al Examinar must be notified at	by Funeral	11. Marilal Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes 2 If Yes 2 If Yes 7 Year or Date	es? □No	13. Was Decedent of A If Yes, specify Cub		cify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: White	itc.	
Maryland 21215-0036	d within 72 jene. r than "nai	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4	or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire P.C.U.	during most of working	ng	Kind of Business/Indi	ustry	
/land	ould be filed Menta! Hygi arked other atic event, II	To Be C	17. Father's Name <i>(First, Middle, Last)</i> Baldwin A. Crawford			18. Mother's Name Amy Iren	(First, Middle, Maide LeRipley	en Surname)		
	d 2 sho th and 7 Is ma trauma		19a. Informant's Name/Relationship <i>(Type, Print)</i> Mirs. Deborah Maskell (Daught	ter) 13	Mailing Address (Street 105 Beaumont	cand Number or Rural Cout, F	Route Number, City ' <b>c</b> est Hill	or Town, State, Zip of Maryland	^{Code)} d 21050	
Baltimore,	Pages 1 nent of H ant: If Ite ary or ott		20a. Method of Disposition  1 Burial 2 TyCremation 3 Removal from Sta 4 Donation 5 Other (Specify)	cemeter	Disposition (Name of y, crematory or other pla Funeral Cha	ce)		Location - City or Tov prest Hill		
Ball	permit. Departm Importa any Inju		21. Signature of Funeral Service Licensee  Hour of Legy-		22. Name and Addre Evans Fune 3 Newport	ral Chape Drive Fo	<u>est Hill,</u>	ion Servio Maryland	ces-BelAir 21050	
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Division of Vital Records,	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director; After this certificate he completely filled in by the funeral director, page		examiner? 1 Yes 2 No Hospital: 1 Inp. 27. Manner of Death 28a. Date of I	njury 28b. Ti	ime of jury 28c. Injur			6  ☐Other (Specify) ury occurred		
DIVIS	tel or Atte s after dea al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building,	Injury - At home, far elc. (Specify)	m, street, factory, office	Bf. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospitel within 24 hours a To the Funeral C completely filled	edicai	29a. Certifier (Check only one)  Certifying Physician: To the Design on the Dasis and manner	of examination and	death occurred at the tire for investigation, in my o	me, date and place, a opinion, death occurre	nd due to the cause( d at the time, date a	s) and manner as sta nd place, and due to	ited. the cause(s)	
)	To T To 1	Σ	29b. Signature and title of coefficien	•	29c. Licens	39022	29d. D	ate signed (Month, D	ZUD7	
3 .	+1		30. Name and address of person who completed cause of	The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa		Utes E	Leve	/MD T	21040	
ž	Sta Registr		31. Date filed (Month Pay Year) 2007	strar's Signature	backer					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Ernest 2007 Ceaser AUGUST 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner G00D MOSPITAL BALTIMORE SAMARITAN Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days 1**∑**M 2□ F Months Hours 250-36-0159 Director 81 8-1-1926 S.C. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at Md. 1 Yes 2 No **Funeral Director** NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 768 Dr. Benjamin Quarles Place 21201 USA 7 is marked other than "natural", or items traumatic event, the Medical Examiner me Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify. 3 Widowed 4 Divorced ear or Dates Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6th grade Construction Whiting Turner Const 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be 2 should be fill and Mental H Harvey Ceaser Queenie Ceaser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Erlene Ceaser Daughter 768 Sr. Benjamin Quarles permit. Pages 1:
Department of He
Important: If Iten
any Injury or oth 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cem. 9-1-07 Baltimore, Md. 22. Name and Address of Facility 21. Sign yure > Funeral Service Licensee March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 23a. Per 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock or heart failure. List only one cause on each line? Approximate Interval Between Onset and Death Imm diate Cause (Final dise se r condition result g in death) Physician SEP515 /Medical Due to (or as a consequence of): Examiner ULCERS DECUBITUS Sequentially list conditions, if any, leading to immediate cause for the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions Due to (or as a consequence of): Examine The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed: death? 1 ∐ Yes 212 No 111 Yes 2 No 25. Was case referred to medical Be 26. Place of Death Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Mann Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred i or Attending Patter death.

Director: After t 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours all To the Funeral D 1 [Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D. RES-000 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) BLUD. BALTIMORE, MD 21239 5601 LOCH RAVEN SAMNATH GHOSH 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

DEMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** LEMENT LUTHER 5:00 a.m. M August 29, 2007 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Ellicott City Health & Rehab Center Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Director February 27, 1925 219.14.0459 South Carolina Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Show 1 Tes 2 No Director 28a-f Maryland Howard Glenwood 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? ŏ Items 23a 21738 3930 Sharp Road U.S.A Funerai Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Deceded to 194 194 Yes, Give 194 Year or Dates: 194 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1943 þ Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural" 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) construction 11 brickmason and Mental Hygie Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 William Clement Annie Rich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 3930 Sharp Road Glenwood, Maryland 21738 Ms. Ada M. Clement Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Burial 2 Cremation 3 Removal from State 09/01/2007 Marriottsville, Maryland Crest Lawn Memorial Gardens 22. Name and Address of Facility Slack Funeral Home, P.A.

3871 Old Columbia Pike Ellicott City, MD 21043 shock, or heart failure) List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or ats a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) P.O. I 9☐ Unknown 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? , page 2 autopsy performed2 2 No 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending hours after death. investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. To the ! 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Back River Neek Hard Sabapally Mayley 2122 31. Date filed (Month, Day, Year) 32 Registrar's Signature 04 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 28088 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Melissa 1050 A 2007 29 AUGUST 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MERCY MEDICAL CENTER BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2 □ F 217-68-3126 36 04/16/1971 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 722 DRYDEN DRIVE 21229 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 ☐ Yes 2 📉 No If Yes, Give X Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 PRODUCTION COORDINATOR TELEVISION / MOVIE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) STANLEY COHEN ARDIS FOWLER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARDIS COHEN 8905 STONE CREEK PLACE #303 - BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5 3 ☐Removal from State BETH TFILOH CONG. 08/31/2007 | WOODLAWN, MD 5 Other (Specify) 21. Sign 22. Name and Address of Facility Funeral/Service Li SOL LEVINSON & BROS., INC. REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) brenst Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an autopsy performed

Other:

Physician /Medical Examiner

death certificate be executed

Box 68760.

P.O.

Division or Vital Records,

Physician:

certificate has

**Physician** 

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

d 2 should be filed within 72 hours after death the and Mental Hygiene. 27 is marked other than "natural", or items 23 traumatic event, the Medical Examiner must

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event

Maryland 21215-0036

Baltimore,

Director

Funeral

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Completed

Be

MD

/Medical

Exami Physician/Medical δ

physician and s the buriaf-transit as nse ю detached is been signed by the should be detached Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be မ Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

1 ☐ Yes 2 ☐ No

4 ☐ Homicide

(Check only one)

29a. Certifier

Medical

2 No 1∐ Yes 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

Bultmar

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 Suicide determined

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

040854

29d. Date signed (Month, Day, Year) 8/24/2007

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

31. Date filed (Month, Day, 32 Registrar's Signature

2007

04

Registrar

State

07-06728

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Joseph Degen 2007 28089 Certificate of Death 1. For State Reg. No. Registrar 2. Date of Death . Decedent's Name (First, Middle, Last) Physician/ Month Day August 30, 2007 0640 hrs Joseph William Degen Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore n/a 3719 Greenvale Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** oreign Min Months Davs Hours July 2, 1986 Country) MD Director 212-13-0113 1 X M 2 F 21 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Y Yes 2 narked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once. n/a Baltimore MD Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 3719 Greenvale Road 21229 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene ant: If item 27 is marked other than "natural", or item 2 Married 1 X Never Married 2 X No Yes White Yes 2 X No specify: Specify If Yes, Give Yea Widowed Divorced à 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Office Furniture Baltimore, MD 21215-0036 0 Installer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dawn C. Snyder Michael Joseph Degen Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3719 Greenvale Road, Baltimore, MD 21229 Mother Dawn C. Degen / 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition it: If it other t 1 X Burial 2 Cremation 3 Removal from State 9/2/07 Baltimore, Loudon Park Ceme. Department or Important: injury or oth Donation 5 Other Specify: 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, MD 2<u>1229</u> Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Death Medical a. Hanging immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last physician and the burial - transi Physician/Medical UNPENDED AMENDED The law requires that the death certificate be 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: 3 Ectopic pregnancy Month Day Year 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 ✓ No 3 Probably 4 Unknown ۵ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? No Yes 2 V No 26 Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Division of Vital Be Hospital: 1 Other₄ Residence 6 V Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 After this 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) Aug 30, 2007 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Certification: Subject found hanging 0000 hrs Yes 2 V No Natural Pending hours after death. Director: Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 3719 Greenvale Road, Baltimore, MD 3 V Suicide Could not be within 24 hours at To the Funeral I determined (Specify) Single Family Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 30, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

DOME

07-06624 James Dehn Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Physician   1-December Name (Fish Missoulary)   1-December Name (F			1- For State Certificate	of Death	Reg. No. 200	7 2809
South Exercises Bayonew Medical Center   South Security Must Secure   South Security Must Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Must Secure   South Security Mu			James		2. Date of Death Month Day Year August 26, 2007	1545 hrs
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State of Maryland / Department of Health and Mental Hygiene 2809 l Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Frank Lyman: Farnham 29 8:04 AM August 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 624 S. Paca St. Baltimore N/AIf Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** New York 1**X** M 2□ F 74 118-26-5641 Director <u>December 30,1982</u> Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Maryland N/A Director Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 624 S. Paca St. 21230 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after nand Mental Hygiene.
Is marked other than "natural", or ite 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No white Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) minister religion/ministry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Hiram Farnham Katherine Doreen Lyman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. Suzanne G. Farnham/wife 624 S. Paca St. Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory Aug. 31, 2007 Baltimore, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
Religione. MD 21212 21. Signature of Funeral Service Licenses 23a /rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final prostecte cencer **Physician** leevs disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗋 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2□ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home Hospital: 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide trifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only and manner stated 29b. Signature and title of certifier 29c. License number 00579360 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) /5 31. Date filed (Month, Day, Year) 326Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

SEP 0 4 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28092 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 1, 2007 **Physician** EVELYN SARAH FREELAND 2:10P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 2714 Paper Mill Road Phoenix Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months September 6, 1922 1 □ M 2 X X 215-12-5832 84 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f sh Examiner must be notified 1 ☐Yes 2√No Director Maryland Baltimore Phoenix 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 2714 Paper Mill Road 21131 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married XX Married 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beautician Beauty Care Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, tt once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Ortho Clough Sarah Marquerite Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarence Edward Freeland Hus. 2714 Paper Mill Road Phoenix Maryland 21131 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Poplar Grove Cemetery: 9/4/07 ☐Donation 5 ☐ Other (Specify) Phoenix Maryland ignature of Funer Service Li 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 nown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) P 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No after death | Director: / 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled in Textifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Day, Year)

Ty St

Registrar

State 31. Date filed (Month, Day, Yea



30. Name and address of person who completed cause of death (Item 23d) (Typ

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State of Maryland / Department of Health and Mental Hygiene 2007 28093 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** August  $3^{\text{Gy}}$ 200**7**° 7:22 p м Nellie Μ. Galusha /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Lutherville Hearthomes Lutherville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Nownth, Days | Hours | Min. | Nownth, Days | 199, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** .^{Yea}I⁾917 89 1 □ M 2 □ X Permsylvania 210-05-9721 Yrs Director Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2X No Baltimore Lutherville Director Md. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be Is any injury or other traumatic event, the Medical Examiner must be Is 21093 1420 Front Ave. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛣 No Specify Specify 9 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary (Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Sugars John Airgood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 710 Burnside Dr. Bel Air, Md. 21015 Mr. Robert W. Phillips/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 9-5-07 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foreral Service Licensee 22. Nampand Address of Easily Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, of complications to a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sta /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE Jse 8 If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown cate has been signated based and bas 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has 1□ Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Livery Freit 2 No 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who empleted cause of death (Item 23a) (Type, Print). Charles St. Balto and Zo 2012 6701 Year) 32. Registrar's Signature 31. Date filed (Month, Day, State 4 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28094 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dav Year Cornelia р Gray 11:40P [™] /Medical 80 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Р G Lanham, Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Rocky Mount, NC **Funeral** Months Days Hours 1 □ M 2 ⋤ F 231-10-7470 94 Director 03/12/1912 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>316 Meads Place N.</u> 20017 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXNo Black ģ Specify Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Press Operator Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å ၉ Arthur Pitman Mary Mitchell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daisy Walston (Sister 16010 Excalibur Road 200-B Bowie Md 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Riverdale Crematory 8/22/2007 | Riverdale, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Austin Royster Funeral Home <u>3821 14th Street N W Washington, D C 20011</u> 23a. Part1. Enter to insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or installure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final diseas or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) the a 9 Unknown been signed by the should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autonsy bettormed. 1□ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 🔲 Yes 1 Thipatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Dettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only

Division or Vital Records, P.O. Box 68760, To the Hospital or Attendia within 24 hours after death. To the Funeral Director: Ar completely filled in by the fu

DHMH 17 HeV 1/2001

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

ECIL

32. Registrar's Signature

7525

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GRO RCE

Greenun

29c. License number

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2 117 28095 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Joseph Melvin Garrett 4:00 A M August 30, 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Home for Hospice Towson Baltimore County Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours Min. DOM 2□ F 217-01-4713 84 Maryland May 20, 1923 Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 200No Director Baltimore Owings Mills Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or 21117 USA 9416 Owings Heights Circle permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces?

★□★Yes 2 □ No
If Yes, Give
Year or Dates: WWII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: white þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Bethlehem Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary G. White Joseph K. Garrett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie Heffner 9511 Tessa Lane Owings Mills, Maryland 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran Cem. 9/4/2007 Owings Mills, Maryland Garrison Forest
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, Maryland 21211 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Juneral Servis Ligensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STAge Parkinsoni Disense **Physician** End. Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical as the L for use a IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1☐ Yes 2☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pr within 24 hours after death, To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 725205 August 30, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St. Balto. and 2,20% 3mc 6 32 Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene 0.7

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/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or	Location of Death		4c. County of D	
		Genesis Health Car			Brooklyn	Park If Under 24 Hrs.		Anne Arun	
Funeral Director			. Sex 7. Age	(In yrs. last birtho	Months Days	Hours Min.	8. Date of Birth (Month, Day,	rear)	Birthplace (State or Foreign Country)
p		212-42-4168 Usual Residence of Decedent		10 O' T			May 11,	1912	AID.
Aaryla Fshov ed at	ō	10a. State 10b. County		10c. City, Town o					10d. Inside City Limits 1 ☐ Yes 2 <b>XX</b> No
r 28a-i notifi	Director	MD Anne Aru  10e. Street and Number	ndel	Linthic	10f. Zip Code		10	g. Citizen of What	: Country?
ith with 23a o ust be	al D	437 Cleveland Rd			21090			USA	
ite; INIAL yial INIAL ZIZIOUOOO  1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It marked other than "natural", or items 23a or 28a-f show idens I's marked other than "natural", or items 23a or 28a-f show idens Irsumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	If Yes, Give	Ever in U.S.	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> <li>Yes 2<b>XX</b>No</li> </ol>	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		merican Indian, Vhite, etc.
POUS 2 hours atural", cal Exar	d ba	15. Decedent's	Year or Dates: Education	16a. D	ecedent's Usual Occup	ation		6b. Kind of Busine	
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iled wi tygien her th nt, the		8 17. Father's Name ( <i>First, Middle, La</i>	ort)		Homemaker	19 Mother's Name	e (First, Middle, M	Own Home	<del>-</del>
d be file antal H ked oth c even	o Be	Leroy Pfeifer	st)			Hazel Leo		laiden Surname)	
2 shoul and M ls marl	F	19a. Informant's Name/Relationship	(Type. Print)	19b. N	Mailing Address (Street a			City or Town, Stat	e, Zip Code)
2 5 ± 2 ±		Janet L. Mewshaw	Daughter		Main Ave SE				
Pages 1 ar		20a. Method of Disposition 1		cemetery,	isposition (Name of crematory or other plac	(e)		20c. Location - City	
partition permit. Pages Department of Important: If is any Injury or of		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lig		Holy Cr	oss Cemetery			altimore, M	4D
Dep de de de de de de de de de de de de de		K. Gregory Fink	M01148		426 Crain I	Hwy S., Gle	n Burnie,		
Physician		23a. Pal.1. Enter the dishash, or chishick, or heart failure. List on Immedia. Cause (Final disease or condition resulting in death)		_	enter the mode of dyin				Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a	a consequence of)					
	ner	Sequentially list conditions,	b. Due to (or as a	Leonaequaries of)					
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ro, Lo. Dox of the death certification by the attending be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p		3 ☐Ectopic pregnancy	,		23d. Date of	*
ne dea the att	sicia	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4□Pregnant at 9□Unknown		5 ☐ Other (specify) _			Month	Day Year
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requires t	d by						1 □ Ye	s 2 □ No 3 □	Probably 4 Unknown
sician: The law requir certificate has been si rector, page 2 should i	Completed						24a. Was an	24b. Were	e autopsy findings available to completion of cause of
The cate h	Сош						perform	od? deati	h?
sician certifi	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	- A [[ [ [ [ ] ] ] ] ]	other SELECT Other		h (Check only one		
g Physer this eral di	n: To	27. Manner of Death	28a. Date of Injur		ne of 28c. Injur	4 Nursing Ho	ome 5 ☐ Resider 28d. Describe ho	nce 6 GOther (5	Specify)
endin sath. or: Aft he fun	atio	1 Natural 5 Pending 2 Accident investigat		Year) Inju		Yes 2 □ No			
lor Att	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home, farm :. (Specify)	, street, factory, office		28f. Location (Str. City or Town,	eet and Number or State)	r Rural Route Number,
To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical Ce	29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	Physician: To the best o amlner: On the basis of and manner sta	examination and/o	death occurred at the tin or investigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manne ate and place, and	r as stated. due to the cause(s)
To the within:	Med				29c. License	e number	29	d. Date signed (M	onth, Day, Year)
->-0		10- Cc	Willan	- has	D3	1136	5	EOTEM	BER 4, 2007
6		30. Name and address of person wh	o completed cause of de	eath (Item 23a) (Ty	rpe, Print)	. O. / A	۸ ۵.	_	Berk 4, 2007 mg 21236
Sta	10	31. Date filed (Month, Day, Year)	32. Reditra	r's Signature	HUGA	IVE R	1) BAC	FIMORIS	ms 21236
Registr		SEP 0	1 2007	H	house to			-	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 28097 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Physician 2:06 PM Catherine Hood tember 1 2-007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5. Social Security Number 6. Sex Medical Conter If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country)
 MD Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 🛣 🗜 F 215-54-3851 Director Jan 13, 1950 Hood Catherine Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits GleN Burnie MD Anne Arundel 1 TYes XXINO Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a USA 21061 721 Wimmer Rd Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2XXNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 💢 No White Specify: þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Government Contrator n and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louise I. Zeller John Petrosky ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 721 Wimmer Rd., Glen Burnie, MD 21061 Important: If item 27 i any injury or other tra Husband Emory Lee Hood, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery Sept 7, 2007 Glen Burnie, MD Funeral Service Lic 22 Name and Address of Facility, P.A. ue Co 426 Crain Hwy S., Glen Burnie, MD 21061 K. Gregory ink 1401148 23a. Part1 Enter the disease or shock or heart failure. plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate wse (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence f **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence Box 68760, attending physician Physician/Medical as the l IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No...... 24a. Was an 1□ Yes 2 ELNO Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 4k ဥ After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director; completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Year)

07-06670 UNK UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 28098

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Funeral Director		5. Social Security 218-76-	Number 6.		Age (in yrs. last t		If Under 1 Ye Months Da		Min	ate of Birth(N		Y) 9. Birth Foreign Coul	
		Usual Residence		-XL	10c. City, Tov		on .	_ 1					10d. Inside City Limit
nd show any, ce,		Md.		JA	Baltimore						Citizen of .V		.1 X Yes 2 N
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and N		Throat	71/	2	10f. Zip Code 2120	01		10g.	USA	What Court	uy:
ath with the Maryland items 23a or 28a-f sho ust be notified at once.	Funeral L	11. Marital Status		12. Was Deced Armed Forc	Apt. 710 ent Ever in U.S. es? 2 X No	13 Was	Decedent of Hes, specify Cubi	ispanic Origin?	( Specify ) uerto Rican	fy Yes or No- an, etc.)  14. Race - American Indian, Black, White, etc.			
P = =	ρ.	3 Widowed	4 Divord	1 Yes ed If Yes, Give Year or Dates: only highest grade		a Docaden	Yes 2 X N	ation (Give kin	d of work d	one 1	Specify 6b. Kind of		ack ndustry
2 should be filed within 72 hours after h and Mental Hygiene. 27 is marked other than "natural", o matic event, the Medical Examiner.	Completed		econdary (0-12)	College (1-4		during mo	ost of working li	fe. DO NOT us	e retired)		Var	ious_	
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d 2 should be th and Mental n 27 is marke aumatic event	To Be	19a. Informant's	Name/Relationship		2.42	19b. Mailing							Zip Code)
a a a a		Lottie	Disposition	Mother  3 Removal from	20b. Pla	ace of Disposematory or ot		cemetery,	Dat	e	20c. Locatio	on - City or	Town, State
permit, Pages I are Department of He Important: If ite injury or other tr	1	4 Donation	5 Other Spe Funeral Service L	cify:	Gr	22. 1	ant Cem	ess of Facility	9-5- Mar	ch F.H	. Eas	st	e, Md.
		40	. 1	omplications that cau	used the death. D		Ol E. I						21202 Approximate Intel Between Onset a
sician/ Medical/ xaminer/		failure. List	only one cause one (Final disease	n each line. a. Gunshot Wo									Death
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ed sit	Examiner	(Disease or inju	nderlying Calific		consequence of):								
te be executed sysician and burial - transit	dical	UNPEND	DED	d AMENDED							Log L D-	to of dollars	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death  To the Funcarial Directors: After this certificate has been signed by the attending physician and commerced Directors, which finered director, page 2 should be detached for use as the burial - transitional physician and commerced filed in two the funeral director, page 2 should be detached for use as the burial - transition.	Physician/Medical	past 12 mo	_	1 Live bi	yes, outcome of pregnancy Live birth 2 Fetal death 3 Ectopic pregnancy  Pregnant at time of death 5 Other (Specify)						Mon	te of delive th	Day Year
that the deatl		Part II. Dther s	No 9 Unk	ons contributing to		sulting in the	underlying cau	se given in Par	rt I.				o the cause of death
Interpretation of vital recordings, 1	1 73								_	24a. Was a autop	sy med?	prior to death?	
The lar	S						26.F	Place of Death	(Check only	1 Yes :	2 No	1 🗸	Yes 2 No
siciam: is certi	e Be	examiner?	referred to medical		inpatient 2	ER/Outpatie	nt 3 DOA	Other ₄	Nursing H		Residence		ner:
ding Phy h After th	on: To	27 Manner of	Death	28a. Date (Month Aug 28,	of Injury , Day Year) 2007	28b. Time o 0239 hrs	,,	Injury at Work  Yes 2	No Su	d. Describe I Ibject was	shot		
DIVISION OF VIGATING OUR Spirital or Attending Physician: The law requirences after death restor. After this certificate has been set Director. After this certificate base been set in his the funeral director, page 2 should	Certification:	2 Accide	ent Inves	d not be	e of Injury - At ho		reet, factory, of	ice building, et		f. Location (S or Town, S 2 South Pa	(atata)		Rural Route Number, ore, MD
To the Hospital within 24 hours To the Funeral			ide	hysician: To the bes	st of my knowledge of examination a		curred at the tin	ne, date and pla inion, death oc	ace, and du courred at th	e to the caus	se(s) and m and place,	anner as s	tated. the cause(s)
To th within To th	Medical	•	and title of certifie	and manners	stated.		29c. L	cense number			29d. Date	e signed (/ t 28, 200	Month, Day, Year)
				who completed cau	se of death (Item	23a)	eet, Baltimi	ore MD 211	201		<u></u>		
		Ling Li,		nt Medical Exa	miner 111			NE, IVID 212					
	Stat istra	~	(Month, Day, Year)	4 2007	egistial s Signat	If for	meter						

State of Maryland / Department of Health and Mental Hygiene 28099 Reg. No Certificate of Death ate c Month 9 Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** LOIS ADELINE HOGARTY 2007 5:00P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 103 GILMORE STREET GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5/21/1931 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months 1 □ M 2 🛣 F 214-26-3379 76 VIRGINIA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 GILMORE STREET 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 ☐ Yes 2☐ No Maryland 21215-0036 Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CASHIER GROCERY d 2 should be filed w h and Mental Hygiei 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HERBERT W. BRIDGEMAN ELIZABETH HESTINE PHILLIPS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health al
Important: If item 27 is
any injury or other trau MR. JEFFREY HOGARTY - SON 127 OLEN DR., GLEN BURNIE, MD 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MD VETERANS CEMETERY 9/7/2007 CROWNSVILLE, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility SINGLETON FUNERAL & CREMATION 21. Signat 1 2ND AVE. S.W., GLEN BURNIE, MD 21061 mondo art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 28 Montus /Medical Due to (or as a core quence of): **Examiner** netastases Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): P.O. Box 68760 Physician/Medical physi as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 1∐ Yes Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 2 1 No P 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 D39505 arkons_M-D Hospital Dr. Glan Sumic, MD. 21061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Markan 305 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Man H fresh Registrar

**ORIGINAL** 

DHMH 17 Hev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** August JEFFERSON 200 /Medical 4c. County of Deat 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 9. Birthplace (State or Foreign Country)
BAHOMD. Social Security Number Year 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 219-30-2809 MAY 20,1936 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene. Important: or items 23a or 28a-f shoy important: If item 27 is marked other than "natural", or items 23a or 28a-f shoy any injury or other traumatic event; the Medical Examiner must be notified at any injury or other traumatic. 1 Nes 2 No BAItO. Be Completed by Funeral Director MD death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21220 TUAIL 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: BIK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MANU Factor Programer 17. Father's Name (First, Middle, Last) JEFFERSON ELIZABETH LONNIE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BAHO. MD JEFFERSON-WIFE timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro CREMATORY 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Michael Ziglier Fun Svc. P.A.
3512 Frederick Ave. Balto. 21. Signature of Funeral Servi Licensee 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due the (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be extended Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical attending pi IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown certificate has been signed l rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an autopsy performed? Yes 27 No 1□ Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural
Accident 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kes 00006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

SEP 0 4 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. NoZ U U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 1 **Physician** lliam ohnson 2887 7:20 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ent ore If Under 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (În yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days 1 <del>4</del> M 2 □ F Months Hours Min 217-24-7229 Director -24 lary/and Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 HYes 2 No Director altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 925 t Vesham Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Ves 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 umas 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Walthers 1229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -12-2007 21. Signature of Funeral Service Licensee 22 Name and Address of A 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congest 1/2 Heav **Physician** /Medical Due to (or as a consequence of) Examiner astatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2 No 3 ☐ Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an the Hospital or Attending Physician: The law hin 24 hours after death. the Funeral Director: After this certificate has t autopsy performed 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No Certification: To 1 ☐ Yeş 1 Inpatient 2 ER/Outpatient 3 DOA  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$ Other (Specify) completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Many er of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) September 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loch Raven Boulevard

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Amend 2,perMD,16a,perFH,g8/1, 9/12/07 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death Month 28 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Jo Barnes James Wanda 3:00p[™] 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore NΑ 433 N. Lakewood Avenue if Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🔀 F 217-68-0461 Director 3-25-1959 48 N.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Di-partment of Health and Mental Hyglene. In portant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumafic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 433 N. Lakewood Avenue 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married
3 Widowed 4 Divorced 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Yes 2√2 No Specify: ģ Specify. Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager 12th grade Cashier Hardy's 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John 2 Hart Tessdisore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Willie 433 N. Lakewood Ave., James Husband Baltimore, Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State Garden of Faith 9-1-07 4 Donation 5 ☐ Other (Specify) White Marsh, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Name and Address of Facility
1101 E. North Ave., Baltimore, 21202 Mđ. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician end stuge Years CIVVHOSIS, disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sarcordost lears Sequentially list conditions, that y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Bivision or Vital Records, P.O. Box 68760, € The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ■ No Month Year Day 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ end stage renal disease, lymphocytic colitis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Mnknown Completed Diabetes Mellitus, 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼No 24a. Was an perforr 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Wither (Specify) Nome hospite 1 ☐ Yes 2 No 2 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 1)47105 cause of death (Item 23a) (Type, Print) 1000 East Eager Street. 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

amendate 5 Maryland POEpathment of Preath and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year 0518 AM lichael JOHNSON August 30 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Center Maryland Baltmore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Muniber Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F 217-66-5777 Director Md. 11-6-1957 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits rral", or items 23a or 28a-f show LExaminer must be notified at 1 X Yes 2 □ No Director Baltimore Md. NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21217 USA 1901 Elgin Avenue Apt. 409 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 Never Married 2 Married
3 Widowed 4 Divorced 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Completed by Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Cook 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Holley Marie Mickey Pierce ဂ္ Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

104 Elyant Avenue: Baltimore, Md. 21217 19a. Informant's Name/Relationship (Type. Print) Mother Marie Mickey Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Description 2 □ Cremation 3 □ Removal from State 4 □ Conation 5 □ Other (Specify) 9-4-07 Lansdowne, Md. Mt. Zion Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 ano 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Endocardity disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LATRIVEROUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Ó. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? My to Ma initial Records, inision or Vital Records, ģ 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 X No certificate 1☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) August 30, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 etimore MD 21201 MOSKOVI Jonth 31. Date filed (Month, Day, 32. Registrar's Signature Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

446001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 200 28105 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Jacobs Sr. Charles W. 6:54 A[™] 29 2007 O8 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner Montgomery Takoma Park, Maryland Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/26/1943 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 √ M 2 ☐ F Yrs. Washington DC 63 Director 578-58-5794 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location ehow. 10b. County item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Michigal Examinar must be notified at Brandywine, Maryland 1 X Yes 2 □ No Prince Georges MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20613 17801 Harvard Road death Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. s filed within 72 hours after I Hygiene. other than "naturel", or Ite 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Marned Black Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: þ 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Plate Maker 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 ie marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) Be Octovia Welch John T Jacobs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4014 Kansas Ave N W Washington, D C 20011 Djakorta Jacobs ( Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 □ Burial 2 □ Cremation 3 □ Removal from State Washington, D C 4 X Donation 5 ☐ Other (Specify) 8/30/07 Univ Medcial Sch 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Lier 3821 14th Street N W Washington, D C 20011 Terry A Austi
23a. Parti. Enter the disease or con Approximate Interval Between Onset and Death tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only open cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physician and the burial-transit that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ģ in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 5 No certificate 1 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗀 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a, Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title o no completed cause of death (Item 23a) (Type, Print) 30 Name and address of person w che 31. Date filed (Morth, Day, Year) 32. Registrar's Signature State 200 Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla		rtificate of		id Melital II	, ,	2007	28106	
	Physici /Medio		1. Decedent's Name (First, Middle, La	James Ha	arley J	ackson		2. Date of D Month	D	ay Year 3, 2007	3. Time of Death 11:43 A M	
	Examir		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, o	r Location of			c. County of Deat	h	
	Funeral Director				s. last birthday) Yrs.	Timoni If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of E Min. (Month, I March	Day, Year	9. Birti Co	more Co.  unplace (State or Foreign  oth Carolin	
	yland how at		10a. State 10b. County	10c. C	City, Town or Lo	ocation			100			
	he Mai 8a-f si otified	ector		ltimore			Dunc	lalk	alk 1 □ Yes			
	3a or 3	I Dir	10e. Street and Number 4054 St. Moni	ca Drivo		10f. Zip Code 21.2	222		"	itizen of What Co n <b>ite</b> d Sta	•	
	r deatl tems 2 er mus	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.			n? (Specify Yes or N Puerto Rican, etc.)		14. Race - Amer Black, White	rican Indian,	
1:43 a.m 215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2☐ No If Yes, Give Year or Dates:	I	1∐ Yes 2∐ANo				Specify:	White	
:43 15-0	n 72 h "natu edical	letec	15. Decedent's E (Specify only highest gr	ade completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	oation during most o	f working	16b. I	Kind of Business/l	ndustry	
11 212	d withi giene. er than the M	Omo	Elementary/Secondary (0-12)  12 Years	College (1-4or 5+)		Manager	-/		Ma	nufactui	ing	
	be file ntal Hy od othe event,	Be	17. Father's Name (First, Middle, Las					Name (First, Middl	le, Maide			
, 2007 Maryland	should be nd Mental marked c	မ	Edward B. Jac		19b. Maili	ng Address (Street		nnie Ander or Rural Route Num		or Town State 7	in Cade)	
	and 2 sealth au		Mrs. Blanche Jac					ive Dunc				
UGUST 28 Baltimore,	Pages 1 nent of He nt: If Iten		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 [	Removal from State	cemetery, cre-	sition (Name of matory or other plac	· ' i	Date	20c. L	ocation - City or	Town, State	
AUGUST Baltimo	nit. Partmer contant injury		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		2:	Cemetery  2. Name and Addre	ss of Facility	31/2007			Maryland	
AU Be	Dep any		Casago E	12		7922 Wise	Ave.	al Home of Dundalk,	_Mar	ındalk, 1 yland 21	nc. 222	
•	Physician /Medical Examiner	-C	23a. Part1. Enter to disease or conshock, or hear the E. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. MYELOFIBROS  Due to (or as a conse	TS quence of):	er the mode of dyir	ng, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death	
68760, 7	rtificate be executed og physician and as the burial-transit	nysician/Medical Examiner	by Physician/Medical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Lisease or injury that initiated events resulting in death) Last	c							
.0. Box	death ce e attendir d for use			nysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregr 1□Live birth 2□Fet 4□Pregnant at time of 9□Unknown	tal death 3[	Ectopic pregnancy Other (specify)	<i>'</i>			23d. Date of deli Month
JACKSON lecords, P	w requires tha been signed I should be det		Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause give	en in Part I.				the cause of death?	
<b>E</b>	The lay	Completed						24a. Wa aut per 1□ Yes	opsy formed?	death?	topsy findings available ompletion of cause of 2 No	
JAMES 'Vital	s certification	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital: 1 ☐ Inpatient 2 ☐	 ER/Outpatier	t 3 DOA Othe		Death (Check only		o <b>W</b> (a) (a)	** TO CD T CD	
0	ing P	$\vdash$	27. Manner of Death  1 Matural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Worl	v at	28d. Describe			ify) HOSPICE	
Division	a a a a	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of injury - At h building, etc. (Spec	nome, farm, str hify)	eet, factory, office		28f. Location City or To	(Street a own, Stat	nd Number or Ru e)	ral Route Number,	
	To the Hospital or within 24 hours after To the Funeral Dit completely filled in	Medical C	29a. Certifier (Check only one)  1 Certifying Pl 2 Medical Exe	nysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, deatl ation and/or in	n occurred at the tin vestigation, in my o	ne, date and ppinion, death	place, and due to the	e cause(s	s) and manner as ad place, and due	stated. to the cause(s)	
	Tot withi Tot	Σ	29b. Signature and title of certifier	2		29c. License	e number	125	29d. Da	ate signed (Month) $8/28/6$	, Day, Year)	
_	10		30. Name and address of person who DR. TARIO MAHMOO		, , , , ,	•				1 01		
	Sta	te	DR. TARIQ MAHMOO	D 2300 DULANE  32 Registrar's Sign		LI KU. T	TWONTO	M, MD 210	93			

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 **Physician** September 1, 2:00 PM Knepper Mary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2948 Edgewood Avenue Baltimore Parkville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 20, 1928 Social Security Number 6. Sex 7. Age (In vrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗙 F 78 Director 220-24-9086 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or ... Examiner must be n 2948 Edgewood Avenue 21234 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married r than "natural", or the Medical Examir 1 ☐ Yes 2√2 No Specify. Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Keller Orpha Mannion other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. 11 Arlen Road, Apt H., Nottingham, Maryland 21236 Matt Knepper son Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory Baltimore City, MD. 4. 2007 21. Signature of Funeral/Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A u 7110_Sollers Point Road, Dundalk,Md. 21222 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ESOPHAGEAL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) ed by the detached 9☐Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 → 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an has autopsy 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 ပ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 🗖 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Baltimore, Maryland 21215-0036

State

Medical

Registrar

DHMH 17 Rev 1/2001

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

PHYSICIAN

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D00584

29d. Date signed (Month, Day, Year)

SEPTEMBER 4,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b perFH, G900, 2/25/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6 **Physician** 3 Day 2007 MICE /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner 9. Birthplace Gounty) Youth west Cente 4 Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) ecurity Number State or Foreign **Funeral** 238.48.5413 Days 1 □ M 2 🗙 F Director 23 193 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Baltimore Mandallsta 1 □Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21133 reens Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) aster Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be rear1 - loud HiHMerrell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8929 Greens Ln Pandallstain mp 21133 heu. Terris hind Baltimore, 20b. Place of Disposition (Accemetery, crematory) (Name of or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore, mo 9.6.07 22. Name and Address of Facility unexus service Voughn C. Green Juneau service 8729 Liberry 21. Signature of Funeral Service License 21133 23a. Part1. Entertine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CADIZA TONY /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): requires that the death certificate be exe P.O. Box 68760, been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably FASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed? Yes 2 No After this certificate funeral director, pag 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 1 Matural 2 Accident 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check o and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2001 twen 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Court Road  $\alpha_d$ Steven Reller 401 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 4 2007 Registrar

07-06314 Clyde E Long

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2007 28   1
Physici	an/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  3. Time of Death
edical Exami	ner	Clyde E. Long  Month August 15, 2007  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
		5220 York Road # 7C Baltimore
Funeral Director		5. Social Security Number unk 1 Mm 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Social Security Number 2 F 49 Yrs. Soci
any		Usual Residence of Decedent  10a. State
Maryland 28a-f show any d at once.	<u>ا</u>	MD Baltimore 1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	I Director	10e. Street and Number  10f. Zip Code 10g. Citizen of What Country?  10s. Street and Number 21204 USA
iter death wi ", or items	Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes 2 X No specify:  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  16. Yes, specify Cuban, Mexican, Puerto Rican, etc.)  17. Yes 2 X No specify:  18. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  19. Specify: black
and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she trammatic event, the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)
-003 I withir giene. Iher th	omb	unk     unk       17. Father's Name (First, Middle, Last)     unk       18. Mother's Name (First, Middle, Maiden Surriame)     unk
21215-0036 nuld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	
MD 2121 ( tid 2 should be fill tilt and Mental I m 27 is marked aumatic event,	7	19a. Informant's Name/Relationship (Type, Print)  0.C.M.E.  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  111 Penn Street Baltimore, MD 21201
imore, MD 2 Pages 1 and 2 shou ment of Health and I lant: If item 27 is n or other traumatic		20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, Date   20c. Location - City or Town, State
Baltimore, permit. Pages I as Department of Hee important: If ite		4 Donation - Xigher Specify: in state
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatite.		21. Signature of Funeral Service Licensee Director State Anatomy Board 655 W. Baltimore Street  Baltimore, MD 21201
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between Onset and
Examiner		Immediate cause (Final disease or condition resulting in death)  a. Hypertensive Cardiovascular Disease  Due to (or as a consequence of):
	-	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated
uted nd ransit		events resulting in death) Last Due to (or as a consequence of):  d  d
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown
P.O. Its that the gned by the detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
cords, P.O. law requires that has been signed b.	ted t	1 Yes 2 No 3 Probably 4 Unknown  24a. Was an 24b. Were autopsy findings available
COCC law re has be e 2 sho	Completed	autopsy prior to completion of cause of performed? death?
of Vital Recoing Physician: The law After this certificate has uneral director, page 2 si		25. Was case referred to medical 26. Place of Death (Check only one)
Vita hysicia this ce	lo Be	examiner? 1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 4 Nursing Home 5 Residence 6 V Other: Scene
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should the control of the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director.	ation:	27. Manner of Death  1 V Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No  28d. Describe how injury occurred
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could not be determined Specify Specify Suicide 4 Homicide Homicide Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specify Specif
To the Hos within 24 h To the Fur completely	Medical	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  O.C.M.E.  August 16, 2007
		30. Name and address of person who completed cause of death (Item 23a)
		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
St Regist	ate trar	31. Date filed (Month, Day, Year)  32. Registrar's Signature
DHMH 17 Rev 1/2		ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 1 per doc 9871 9-11-07 vt.
State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Wilbert Lyons Day Month 8 **Physician** 200^{Year} Walter 24 6:50p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richy Hospice Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In vrs. last birthday **Funeral** Months 1 M 2 □ F 241-52-3229 Director 72 2-29-1934 N.C Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1√2 Yes 2 □ No Director Md. NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1444 Ward Street Funeral 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Race - American Indian, 11. Marital Status Examiner Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: r than "natural", or the Medical Exami Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify þ Specify: Black 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry School Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygier 7 is marked other th 8th grade Custodial Baltimore Publi or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Powell Powell ပ္ Emmal Lyons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If Item 27 is any injury or other trau Marvin Lyons 1023 Tompaine Drive, Lancaster, Pa.17603 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Trinity Cem. 8-31-07 Dundalk, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East Joseph R. Walters | 1101 E. North Ave., Ba. 23a. var1/ Enter th. disease, or complications that caused th. Do not enter the mode of dying, such as cardiac or respiratory arrest, hoc., or heart failure. List only one cause on each line. Baltimore, 21202 Md. Approximate Interval Between Onset and Death Imm di se Cause (Final dise se or condition resu ng in death) Esomo je: Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached o 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed Yes 2 No certificate has 1∐ Yes Division or Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) Hospice Hospital: 1 ☐ Yes 2 ☐ No ² 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide hours after e Funeral 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certife 29c. License number 29d. Date signed (Month, Dav. Year) 0

Registrar

State

BANIN

31. Date filed (Month, Day,

24/07

W. hehe

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

26,200

Bu/timose MD 2(210-1303

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of N	/laryland / l		ment of Hicate of		nd Mer	ital Hyg	jienę leg. No	007	2811	1
	Physic /Medi		1. Decedent's Name (First, Midd. Edna	Roberta	Stoke	s	Lane			Date of Dea Month	Day	Year 2007	3. Time of Death 7:25p	M
	Exami	ner	4a. Facility Name (If not institution 2567 Cecil	Ave.				ltimo	re			ounty of Death		
£.	Funeral Director		5. Social Security Number 219-26-4381  Usual Residence of Decedent	6. Sex 7. A	Age (In yrs. last bi		Under 1 Year onths Days	-	Min.	Date of Birth Month, Day -7-19	, Year)	9. Birthp Coun	lace (State or Fore try)  Md.	ign
	ne Maryland 8a-f show otified at	ctor	Md. NA		10c. City, Tow		imore					1	0d. Inside City Limi	
	ath with the s 23a or 2 nust be no	Funeral Director	10e. Street and Number 2567 Cecil A					218				n of What Coun		
920	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Mar  3 □ Widowed 4 □ Divorced	ried 12. Was Deceder Armed Forces 1 ☐ Yes 2 If Yes, Give Year or Dates	s? ] No		Decedent of H s, specify Cuba Yes 2 No	lispanic Origin an, Mexican, P Specify:	i? (Specify Puerto Rica	Yes or No- in, etc.)		. Race - Americ Black, White, o Decify: Bla	etc.	
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2	1 and 2 shou Health and M em 27 Is mar other traumati	F	19a. Informant's Name/Relations Walter Lane		196	o. Mailing Ad	ddress (Street a	and Number o	or Rural Ro		r, City or T	own, State, Zip		
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any Injury or othe once.		20a. Method of Disposition  1 Surial 2 Cremation  4 Donation 5 Other (S	Specify)	20b. Place o cemete	f Disposition ery, cremato Cison	n (Name of ry or other place Fores me and Addres	st Vet	Date		20c. Locat	tion - City or To		— М
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	Physician /Medical Examiner	ier	s ock, or heart failure. List Im reviate Cause (Final dise se or condition resulting in death)  Sequentially list conditions, If any, leading to immediate cause. List Underlying Cause (Disease or injury)	a Due to (or a	s a consequence	viey of):	1 0	mes					Interval Between Onset and Death	
8760,0	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a	s a consequence	of):							-	_
.O. Box 6	that the death certifica hed by the attending ph detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months2 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown		e pf pregnancy 2  ☐ Fetal death at time of death		opic pregnancy er (specify)				23d	. Date of deliver	ry Day Year	
ords, P.	w requires that been signed k should be det	þ	Part II. Other significant condition	ons contributing to death	but not resulting ir	n the underl	ying cause give	en in Part I.	_		acco use		e cause of death? ably 4 ∐Unknow	vn
al Rec	The ate has page	Completed	OF W								y ned?	24b. Were autop prior to con death? 1 ☐ Yes	sy findings availab pletion of cause of 2⊡ No	le f
Division or Vital Records,	To the Hospital or Attending Physician: within 24 hours after deals.  To the Funeral Director: After this certification in the funeral director, completely filled in by the funeral director,	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner Death  1 Natural 5 Pendin investig	Hospital: 1 Inpat  28a. Date of Inj g (Month, D	ury 28b. 7	itpatient 3 Time of njury	DOA Othe	4 ⊔ Nursin ⁄ at	ng Home		nce 6 🗆	Other (Specify	)	
Divis	Hospital or Att 24 hours after de Funeral Direct stely filled in by t	Certification:	3 Suicide 4 Homicide 6 Could r determ	ined 286. Place of in building, 6	ljury - At home, fal tc. (Specify)				(	City or Town	, State)	lumber or Rural	,	
	To the Hos within 24 ho To the Fun completely	Medical	(Check only one)  2 Medical  29b. Signature and title of centries	g Physician: To the bes Examiner: On the basis and manner s	of examination an	id/or Investir	nation in my or	ninion death c	occurred at	the time d	ate and pla	d manner as sta ace, and due to igned <i>(Month, E</i>	the cause(s)	
	9		30. Name and address of person	Who completed cause of	M L D  death (Item 23a) (	(Type, Print)	29c. License D  The ma	3897	2	8	3/29/0	7		-
	Sta		24/1W. Belveo 31. Date filed (Month, Day, Year)	dere Ave 132. Regist	105 206 rar's Signature	Bol	eto ma	2/21	5			·	<u>.</u>	
DH	Registr JH 17 Rev 1/20		SEP	0 4 2007	Page 10 1 B	1 As	ente							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Sept. 2007 6:40 AMM **Physician** Lester Ruth W. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Sykesville Brinton Woods Nursing Home 8. Date of Birth

(Month, Day 8 ear)

1926 Birthplace (State or Foreign Country)
 Germany If Under 1 Year | If Under 24 Hrs._ 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 212-70-3023 1 □ M 2 X X 81 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Glen Burnie MD Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 21061 1422 Houghton Road United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXXNo Specify Saltimore, Maryland 21215-0036 ģ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lemke Anne Phillipp Fritz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jessup, MD 20794 8249 Glen Ct. daughter Elfie Winstead 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any Injury or o 1 ☐ Burial 2XXCremation 3 ☐ Removal from State South Carroll Crematory Sept. 4, 2007 Winfield, MD 4 □ Domation 5 □ Other (Specify) ^{22. Name and Address of Facility}
Burrier-Oueen Funeral Home & Crematory, PA
1212 W. Old Liberty Road Winfield, MD 21784 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a Part | Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be efecuted Due to (or as a consequence of): attending physician a for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) s been signed by the serviced is 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1∐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

TOWN LIBORTY RD ELBORIBURE MD 21784

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

04

31. Date filed (Month, Day,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #16a,perFH,C871,9/4/07 TT Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician August 2007 Lynn Laura D. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A timore Cul 8. Date of Birth (Month, Day, Year) 05/06/1939 9. Birthplace (State or Foreign Under 24 Hrs. 6 Sex **Funeral** Min. Maryland Months Davs 1 □ M 2 □ F 216-36-6619 68 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County orant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1. Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, 2906 North Calvert Street 21218 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event. the Max Elementary/Secondary (0-12) College (1-4or 5+) Clerk Clerk Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Cyril Sharff Ethelyn Wolf ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Jupiter. FL. Charles Sharff - Brother 1536 Treemount Avenue 33469 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Cemetery 09/01/2007 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Kimberly Davidson Baltimore, Maryland w eonard J. Ruck. Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ardiae /Medical Due to (or as a consequence of): Examiner peratou Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of): (or as sician and burial-transit monar Due to (or as a consequence of) ng physician as the burial-P.O. Box 68760, Physician/Medical certificate has been signed by the attending rector, page 2 should be detached for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available perform 2 No 1 Yes 25. Was case referred to medica examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 TYes 2 No 1 Thpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death. 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and itle of certifie 00063322 2007 s of person who completed cause of death (Item 23a) (Type, Print) 30 Name and adds HOSPITAL OF BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day Year 00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMIRE REHABILITATION EXTER 7. Age (In yrs. last birthday, 82 Yrs. If Under 1 Year 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** Days Hours 03/2271925 ear) 1 ☑ M 2 □ F Mar VTand Director 214-14-0998 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-f shov must be notified at Maryland Baltimore Director Parkville 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? with t items 23a 2603 Windsor Road 21234 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after deathnent of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: þ Specify. 3 Widowed 4 □ Divorced WII White Completed or than "naturi 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Crown_Cork & Seal 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Lahey ပ္ Mary Fryer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar important: if Item 27 is any injury or other trauonce. David Lahey - Nephew 910 Saxon Hill Drive Cockeysville, Maryland 21030 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/06/2007 Parkville, Maryland 4 Donation 5 Dother (Specify) 21. Signatura of Funeral Service License 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck. uno Inc. Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical the attending ph I for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) □Yes 2 No been signed by the should be detached 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? certificate 1∐ Yes 2□No 2 🔀 No Hospital or Attending Physician; director. 25. Was case referre examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**X** No Certification: To 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No nours after death, neral Director: / filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4.41 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

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ek.	Funeral Director		5. Social Security Number 6. Sex 214-20-1662	7. Age (In yrs. last 80		Il Under 1 Year Months Days	Hours Min.	8. Date of Birtl (Month, Day Nov 5,	r, Year)	9. Birthpla Countr Mary1	ace (State or Foreign y) and
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more,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☒ Donation 5 ☐ Other (Specify)	20b. Place	e of Dispositi etery, cremai	on (Name of tory or other place	e) Da			11D ZI	853 n, State
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			30. Name and address of person who comp	leted cause of death (Item 23a)	(Type, Prin	IF PO	BOX 17	73	Saliet	_ u	ND 21802
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HUNT, McDamel Year Month William 1159 AM **Physician** 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 5757 Cede 4b. City, Town, or Location of Death Examiner Howard County General Hospital
5. Social Security Number of a say Howard Count lane Columbia, Maryland If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Mpnth, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1'▼ M 2□ F 180 27/ MICHIGAN Director 368.24.3260 Usual Residence of Decedent 10d Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County show ns 23a or 28a-f shov must be notified at 1 ☐Yes 2☐ No Director HOWARD SAVAGE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 20863 8560 STORCH WOODS DR. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1111 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. 1 Never Married 2 Married ō 1 ☐ Yes XX No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced WHITE "natural"; Completed 16b. Kind of Business/Industry 7 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COLLEGE OF OB/GYN ADMINISTRATOR 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental H Be GERTRUDE HUNT 2 KAARVAND C. McDANNEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i 29817 SOUTH COTTAGE GROVE AVE. BEECHER IL 60401 JAMES M. McDANNEL 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. 1 WBurial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) LAKESIDE CEMETERY 9.5.2007 PORT HURON, HI 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. t/a MARYLAND MORTUARY SUPPORT 21. Signature of Funeral Service Licerise K. CREGORY FINK NO1148 426 CRAIN HMY S GLEN BURNIE, MD 21061 23a. Par 1. Enter the tiss se, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. ck, or heart faller. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or indition resulting in death) **Physician** Due to (or as a construence of): Vascular /Medical **Examiner** Due to or s a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hyper ten 51% Division or Vital Records, P.O. Box 68760 or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ∐Yes 2 ∐ No certificate 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 □ DOA 1 ☐ Yes 2 ☐ No 1 Inpatient Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident in Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital a within 24 hours af To the Funeral D Lecritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmed

4

5755

32. Registrar's Signature

DEREUS.

29c. License number

Cedar Lane, Columbia

29d. Date signed (Month, Day, Year)

31107

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Morabito Joseph 1:50 AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore VA Kehab + Extended Care Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Hours 188-18-3417 82 Director -22-1925 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified 1 ☐ Yes 2 No Director Middle Baltimore 10e. Street and Number 10g. Citizen of What Country? with Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or important: if item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 ence. 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Yes 2 K No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sergeant Master 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be ည Morabito atherine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest 9 Balhmore Md 21220 <u> Norma Morabito - wife</u> 20a. Method of Disposition Date Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) netery 22. Name and Address of Facility Econs Fune 9-5-07 Owings Mills 21. Synalus, of Fundal Selvice Liversee Evans Funeral Chapel & Cremation Sur-Parkville 8800 Harford Road Parkville md 21234 23a. Part1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician stege End /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit death certificate be executed Due to (or as a consequence of): Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) P.O. 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 Yes 2 → No 3 Probably 4 Unknown page 2 should buillahou 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No performed' 2 **₽** No Common 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending 1 Natural 1 Yes 2 No 2 Accident 24 hours after death • Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 247804 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blvd. Baltimore MD Lock Raven 3900 MROWIFC 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** September 3, 2007 1:00pm Mary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson If Under 24 Hrs. If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 5-13-1924 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Min 1 □ M 2 🖺 F 212-20-6266 8 3 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☑No Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number )SA Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify. δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore Cour Elementary/Secondary (0-12) College (1-4or 5+) -ibraru 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1ce ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltmore
Date 20c. Location Md 21234 8707 Huenue hobert Merrey 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 7-2007 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) ignature of Furieral Service Licensee 22 Name and Address of Facility Evans Funeral Chapel & Cremation Sur-Parkville 8800 Harford Road Parkville md 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical onsequence of): Examiner MOV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner execorded physician and the burial-transit Due to (or as a consequence of) Box 68760 pe Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. I been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform this certificate Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: Aft

completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 35 Ni Charles St 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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			1. Decedent's Name (First, Middle,	Last)					2. Date of Deat Month		3. Time of Dea	ath
	Physic		THOMAS	HENRY MAF	RTIN				AUgust	31 200		AM
F	/Medi Exami		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, or	Location of Death	0	4c. County of D	eath	
			SHADY GROVE H	OSPITAL			GAITHER	SBURG		MONTGO	MERY CO	
1	Funeral			i. Sex 7. Ag	ge (In yrs. la	ast birthday	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Fo Country)	reign
	Director		230-07-7738	îXOXM 2□F	8	9 Yrs.	monaro Bayo	110010	OCT 17	1917 V	IRGÍNIA	
	PL ,		Usual Residence of Decedent		1 100 City	, Town or l	ocation				10d. Inside City Li	imite
	arylar show	_	10a. State 10b. County		Too. Oily,	, 10***** 01 1	Location				1 □Yes 2K	
	e Ma Ba-f	cto		GOMERY	1		GERMAN	TOWN				
	or 2	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What	•	
	ath w	교	P.O. BOX 1772				208		7. 1/2	U.S.A.	merican Indian,	
	er de tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces' d 1 (2) Yes 2 □	?	5.   13	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		/hite, etc.	
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes Ž <b>O</b> XNo	Specify:		Specify: E	BLACK	
THOAT 21215-0036	hour tural al Ex		15. Decedent's	1	43/43	16a. Dec	edent's Usual Occup	ation		16b. Kind of Busine		
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3 2	with iene thai	E	Elementary/Secondary (0-12)  12th grade	College (1-4or	3+)	MA	THEMATICAL	ENGINEE	R	APG		
	Hyg other ent,	Be C	17. Father's Name (First, Middle, L.					18. Mother's Name	e (First, Middle, I	Maiden Surname)		
A La	ld be enta <b>ked</b> ic ev	To B	THOMAS L. MART	IN				unknowi	n			
Maryland 21215-	shou nd M mar	-	19a. Informant's Name/Relationshi	(Type. Print)		19b. Ma	iling Address (Street			r, City or Town, Stat	e, Zip Code)	
_	nd 2 alth a 27 is		Carolyn M. Dave	nport/Daugh	nter	PO	Box 1772	, German	town, Md	., 20875		
ē	is 1 a		20a. Method of Disposition		20b. Pl	ace of Disp	position (Name of rematory or other place	ce)	Date	20c. Location - City	or Town, State	
5	Page tent on t: If ry or		1 A Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Sp.		4	LAIR I	MEMORIAL	09-08	8-07	BELAIR, M	IARYLAND	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fin 1 Service	cellee	, =		22. Name and Addre					
ä	permi Depa Impo any Ir		1///	Denne			MM C BROWN 321 S. PHI	LADELPHIA	A BLVD.,	AL HOME-F ABERDEEN	ARFORD P.A , MD 21001	4.
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that cause	d the death						Approximate Interval Betwee	en
	Physician		Immediate Cause (Final disease or condition		UMOR	114					Onset and Deat	th
	/Medical		resulting in death)	Due to (or as	_						4-2-10	
221	Examiner		CONTRACTOR STORMS	b								
-	Charles State	je	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as	s a consequ	ence of):						
V	icate be executed physician and s the burial-transit	Examiner	that initiated events	c								
0	e exe ian a urial-1		resulting in death) Last	Due to (or as	s a consequ	ence of):						
68760	ate be nysici	Medical		d								
	ng pl	Med	IF FEMALE:									
Box	requires that the death certificate be een signed by the attending physicia nould be detached for use as the bur	Physician/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐Live birth	2 Fetal	death 3	B ☐ Ectopic pregnancy	1		23d. Date of Month	delivery Day Year	r
	e deg	Sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of de	eath 5	Other (specify)	-				
P.0	d by tetach	Phy	Part II. Other significant condition	e contributing to death	but not resu	Iting in the	underlying cause giv	en in Part I	23e. Did tol	hacco use contribut	e to the cause of deatl	h?
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or o	w requir been s should	ted	No propriet									
ec	law lasb	lg/							24a. Was a autops perfor	sy prior	e autopsy findings avai to completion of cause	ilable e of
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- Z	Physician: The lav this certificate has ral director, page 2.3	은	1 ☐ Yes 2 No	Hospital: 1 Inpat		ER/Outpati		4 Li Nursing H		ence 6 Other (	Specify)	
2	Ing F	on:	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Inj (Month, D	ay Year)	28b. Time Injury	/ Wor	yal k?   Yes 2 □ No	200. Describe no	ow injury occurred		
Sio	Attending r death. ector: After oy the fune	cati	2 ☐ Accident investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation in		ium. At hou	mo form	street, factory, office	res 2 🗆 NO	29f Location (St	troot and Number o	r Rural Route Number,	
Division or Vital Records.	or At fter d Direc in by	Certification:	4 ☐ Homicide determin	Zoe. Flace Ul II	etc. (Specify	) )	street, factory, office		City or Town		Titiai Tioute Number,	3
	pital urs a eral [		29a. Certifier 1 Decertifying	Physician: To the bes	t of my know	wledge de	ath occurred at the ti	me date and place	and due to the o	ause(s) and manne	r as stated.	
	Hos 24 ho Fun	lica	(Check only 2 Medical E	xaminer: On the basis and manner s	of examinat	tion and/or	investigation, in my	opinion, death occu	rred at the time, o	date and place, and	due to the cause(s)	
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical	29b. Signature and title of certifier	1 1	1		29c. Licens			29d. Date signed (M		
	F 3 F 8		NAL 11	Wand	an		290	453		Avenst	31, 200	7
	111		30. Name and address of person w	the completed cause =	death (Itam	23al /Tim	e Print)			1	,	
	H		A		death (Item	(HA)	0-1 GRAIG	RA Ru	rekulle	E Mn)	CIRO	
	e.	ate	31. Date filed (Month, Day, Year)		trar's Signat	ture	1 0		-/- /	- 1.119		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 2007 **Physician** August 26, 1:00 AM M Betty Jane Martin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Timonium Stella Maris Hospice Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔽 F 81 Mar 3, 1926 California Director 557-30-8520 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2√ No Director MD Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 242 Brookwood Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) oermit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 0 secretary advertising agency 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John William Pullen Isabel Muir 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 242 Brookwood Avenue Easton, MD Louis Martin/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Rona Ld S Wayte 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street , Director **Physician** /Medical **Examiner** use as

physician and s the burial-trans Division or Vital Records, P.O. Box 68760 ed by the attending detached for use as BETTY MARTIN

1:00 a.m.

AUGUST

Baltimore, Maryland 21215-0036

	/m////	Balt	imore, MD21201								
	23a. Pa 1. Enter the dis se, or comp shock, or heart failure. List only o	lications that caused the death. Do not enter the one cause on each line.	e mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death						
	Immediate Cause (Final disease or condition	OVARIAN CANCER									
	resulting in death)	Due to (or as a consequence of):									
-	Sequentially list conditions,	b. Due to (or as a consequence of):									
ا قِ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,									
am	that initiated events resulting in death) Last	c									
<u> </u>	roballing in doddin addi	Due to (or as a consequence or).									
ca	•	d									
ed					l						
\$	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnancy		23d. Date of de	elivery						
Sia	in the past 12 months?		opic pregnancy er (specify)	Month	Day Year						
/sic	1 ☐ Yes 2 INo 9 ☐ Unknown	9□Unknown									
Completed by Physician/Medical Examiner	Part II. Other significant conditions co	23e. Did tobacco use contribute t	to the cause of death?								
þ	Part II. Other significant conditions of	1 ☐ Yes 2 ☐ No 3 ☐ F	robably 4 Unknown								
eq		TILLIES ZILINO SILIF	Tobably 4 10 Introvin								
Set				24a. Was an 24b. Were a	utopsy findings available completion of cause of						
Ē				performed? death?	s 2 No						
			00 Plans of Parks	A	s ZLINO						
Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death (								
To I	1 Yes 2 X No	1 Inpatient 2 EH/Outpatient 3	4 Nursing Home	e 5 Residence 6 Other (Sp	ecify) HOSPICE						
Ë	27. Manner of Death  1 ▼ Natural 5 □ Pending	28a. Date of Injury 28b. Time of (Month, Day Year) Injury	Work?	3d. Describe how injury occurred							
atic	2 Accident investigation		/ 1 ☐ Yes 2 ☐ No								
fic	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, building, etc. (Specify)	factory, office 28	3f. Location (Street and Number or F City or Town, State)	Rural Route Number,						
ert	4 Tromicide	building, etc. (Opechy)		ony or rown, clarcy							
2	29a, Certifier 1X Certifying Phy	ysician: To the best of my knowledge, death occ	curred at the time, date and place, ar	nd due to the cause(s) and manner a	as stated.						
ji Ci	(Check only 2 Medical Exam	iner: On the basis of examination and/or investi	gation, in my opinion, death occurre	d at the time, date and place, and du	ie to the cause(s)						
Medical Certification:	29b. Signature and title of certifier		29c. License number	29d. Date signed (Mor	nth. Dav. Year)						
	255. Signature and the or continer	)	D1.222		/						
		1	1047725	8/27,	101						

Registrar DHMH 17 Rev 1/2001

State

2300 DULANEY VALLEY RD.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

0 4

TIMONIUM, MD 21093

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar Amend #30, pe	rDVR,g871,9/4/07	TT C	ertificate of	Death	Reg. N	- Z 11 11 1	28122
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, La      A A Y      4a. Facility Name (If not institution, give	J		7 C C U L L .  4b. City, Town, o		UGUSTO	Day Year  28 2007  4c. County of Death	3. Time of Death
	Funeral Director		219-20-3042		. last birthd	ay) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Yea	9. Birthol Count 1937 Mary	ace (State or Foreign try) Land
	e Maryland 3a-f show tifled at	Director	Usual Residence of Decedent  10a. State 10b. County  MD Queen A	-	ity, Town or Centr	Location eville			10	0d. Inside City Limits 1 □Yes 21□No
	th with th 23a or 28 ust be no		10e. Street and Number 205 Armstrong A	venue		10f. Zip Code	21617	10g. (	Oitizen of What Count USA	ry?
0500-0	uges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	J.S. 1	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 【 No	lispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	fy Yes or No- caп, etc.)	14. Race - America Black, White, e	etc.
0-6171	within 72 ho iene. • than "natur the Medi ai I	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12	ducation ade completed)  College (1-4or 5+)	(G lift	cedent's Usual Occup ive kind of work done e. DO NOT use retire Ookkeeper	oation during most of working d)	16b.	Kind of Business/Ind	lustry unk
ם מ	12 should be filed within h and Mental Hygiene. 7 is marked other than traumatic event, the Me	Be	17. Father's Name (First, Middle, Last	)		okkeeper	18. Mother's Name (I	First, Middle, Maid	en Surname)	
1736	should nd Mer marke matic	ြင	Charles Wesley D		19b. M	ailing Address (Street	Anne Mari and Number or Rural I	e Seligm	an v or Town, State, Zip	Code)
, Ma	1 and 2 s Health ar em 27 is other trau		David McCulloug	h/spouse			g Avenue Ce		· ·	
altimore	a la k		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☒ Donation 5 ☐ Other (Special	fy)	Place of Di cernetery, o	sposition (Name of crematory or other place			Location - City or To	
0	permit. Pag Department Important: I any Injury o		21. Signature Luneral ryice Licel KON 11 d	Wade hirecto	r	State Ana Baltimore	tomy Board MD 21201	655 W. E	Baltimore	Street
	Physician /Medical Examiner		23a. Part I. Enter the disease, or comshoot, or heart failure. List only Immediate ause (Final disease or c. ndition resulting in death)	plications that caused the dea one cause on each line.  a	A24		ng, such as cardiac or i		1	Approximate Interval Between Onset and Death
on,	rificate be executed ig physician and as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	BE	765	WELLT	Tus		
00/00	tificate ig phys as the	Medical		_d			2127 12 3			
.O. DOX	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	al death	3 □Ectopic pregnanc 5 □ Other (specify) _	У		23d. Date of deliver Month	ry Day Year
cords, r	equires that en signed b ould be deta	þ	Part II. Other significant conditions of	N6			en in Part I.		o use contribute to the	
שו שבני	: The law r cate has be ; page 2 sho	Completed		HOLESTEI		MIAD	FIEASE	24a. Was an autopsy performed? 1∐ Yes 2 €	prior to con death?	osy findings available inpletion of cause of
N Ka	/sician s certifi lirector	o Be	25. Was case referred to medical examiner?  1 Yes 27 No	Hospital: 1 ☐ Inpatient 2	7√E B/Outpa	tient 3D DOA Oth	26. Place of Death (		6 □Other (Specify	
0 10	To the Hospital or Attending Physician: The law within 24 burus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Tim Injur	e of 28c. Injur		d. Describe how in		/
	al or Atte s after des al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of injury - At I building, etc. (Spec	nome, farm, ify)	street, factory, office	28	f. Location (Street City or Town, Sta	and Number or Rural ate)	Route Number,
	te Hospit 24 hours ie Funera bletely fille	Medical (	29a. Certifier (Check only one) 1₩ Certifying Property 2   Medical Example 1   Medical Example 2   Medica	nysician: To the best of my kr miner: On the basis of examir and manner stated.	owledge, do	eath occurred at the ti r investigation, in my	me, date and place, an opinion, death occurred	d due to the cause I at the time, date a	e(s) and manner as stand place, and due to	ated. the cause(s)
	Vithii Vithii Comp	Me	29b. Signature and title of certifier	12	11 >	29c. Licens	e number	29d. [	Date signed (Month, L	Day, Year)
			30. Name and address of person who	completed cause of death lite	m 23a) (Tvi	pe, Print)	95073		912810	+
			Eric F. Ciganek, MD	CHester River Hos	pital					
	Sta Registi		31. Date filed (Month, Day, Year)	32. Region's Sign	, K	Sparke	;			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend #30, perDVR, g871, 9/4/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** anie 26 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Count 8. Date of Birth (Month, Day, Year Age (In yrs. last birthday 9. Birthplace (State or Foreig **Funeral** Hours 1 **☑** M 2 □ F Months Min. 214-18-9953 85 May 11, Director 1922 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 28a be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Director Baltimore 1√Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 148 South Way Lane 21218 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No If Yes, Give Year or Dates:

142— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No 2 Specify: Specify: white 142-44 3 Widowed 4 Divorced Completed unia: CHIK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) the M Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Miller ပ Reba Ratner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genesis Randallstown 9109 Liberty Road Randallstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once, 4 N Donation 5 ☐ Other (Specify) Ronald Service icensee Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Examiner If any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has page 2 s autopsy performed? certificate 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 2 1 Inpatient 4 Hursing Home 5 Residence 6 ☐Other (Specify) 27. Manner 28a. Date of Injury (Month, Day 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? Division 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 296 Signature and 29d. Date signed (Month, Day, Year) 30. Nave an address person who completed cause of death (Item 23a) (Type, Print) Jocelyn N El-Sayed, MD Genesis Randallstown, MD 31. Date filed (Month, Day, Year) 32. Pagistrar's Signatur State

Registrar

To Be Completed by Funeral Director	Scial Security Number  217-77-0381  Sual Residence of Decedent  Ca. State  10b. County  Md.  NA  Co. Street and Number  6124 Northwood  1. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's  (Specify only highest  Elementary/Secondary (0-12)  Infant  7. Father's Name (First, Middle, Later's Name (First, Middle, Later's Name (First, Middle, Later's Name)  9a. Informant's Name/Relationship  Ebony Bailey  10a. Method of Disposition  1 Donation 5 Other (Spetal Service Lie)  1. Signature of Funeral Service Lie	Dr. Apt. B  12. Was Decedent Ever Armed Forces? 1   Yes 2   No   If Yes, Give A Year or Dates:  Education grade completed)  College (1-4or 5+)  Matthew of (Type. Print)  Mother  B   Removal from State   Removal from Sta	16a. Dece (Give life.) 19b. Maili 612 20b. Place of Dispo cemetery, cre King M	Balk  If Under 1 Year Months Days 7 19  ocation  more  10f. Zip Code 2121  Was Decedent of If Yes, specify Cub  I Yes 21 No edent's Usual Occupe kind of work done DO NOT use retired.  Infant  ing Address (Street 24 Northwo	If Under 24 Hrs. Hours Min.  2  Hispanic Origin? (Span, Mexican, Puerto Specify: pation during most of world)  18. Mother's Nam Ebony and Number or Ru	8. Date of Birth (Month, Day, 1-11-()  Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Ye	Og. Citizen of What Co USA  14. Race - Amel Black, White	hplace (State or Foreignantry)  Md.  10d. Inside City Limits  1 Yes 2 No nuntry?  nican Indian, e, etc.  Lack  Industry	
To Be Completed by Funeral Director	Social Security Number  217-77-0381  sual Residence of Decedent Da. State  10b. County  Md.  NA  De. Street and Number  6124 Northwood  1. Marital Status  1 Never Married 2 Married 3 Widowed 4 Disposition (Specify only highest Elementary/Secondary (0-12)  Infant  7. Father's Name (First, Middle, Later) Don  9a. Informant's Name/Relationship Ebony Bailey Da. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 2)	Dr. Apt. B  12. Was Decedent Ever Armed Forces? 1   Yes   2   No   If Yes, Give Year or Dates:  Education grade completed)  College (1-4or 5+)  Matthew O (Type. Print)  Mother	n yrs. last birthday, Yrs.  Dc. City, Town or Lo Balti  r in U.S. 13.  16a. Dece (Give life.  19b. Maili 612  20b. Place of Disp. cemetery, cre King M.	ing Address (Street P.4 Northwoosition (Name of matory or other place)  If Under 1 Year Months Days 7 19  If Under 1 Year Months Days 7 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 19  If Under 1 Year No 1	If Under 24 Hrs. Hours Min.  2  Hispanic Origin? (Span, Mexican, Puerto Specify: pation during most of world)  18. Mother's Nam Ebony and Number or Ru	8. Date of Birth (Month, Day, 1-11-()  1-11-()  Decify Yes or Nobe Rican, etc.)	Og. Citizen of What Co USA  14. Race - American Black, White Specify: B1  16b. Kind of Business/i  NA Maiden Surname) Bailey r, City or Town, State, 2	Md.  10d. Inside City Limits 1 √ Yes 2 □ No untry?  rican Indian, e, etc.  Lack Industry	
To Be Completed by Funeral Director	Da. State  Md.  NA  De. Street and Number  6124 Northwood  I. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  (Specify only highest  Elementary/Secondary (0-12)  Infant  7. Father's Name (First, Middle, Later)  Don  9a. Informant's Name/Relationship  Ebony Bailey  Da. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spe	Dr. Apt. B  12. Was Decedent Ever Armed Forces? 1	Balti rin U.S. 13. 16a. Dece (Give life.  19b. Maili 612 20b. Place of Dispremetery, cre King M	More  10f. Zip Code 2121  Was Decedent of Hif Yes, specify Cub. 1 Yes 2 No dent's Usual Occupe kind of work done DO NOT use retired. Infant  Infant  24 Northwo	Hispanic Origin? (Span, Mexican, Puerto Specify: pation during most of world)  18. Mother's Nam Ebony and Number or Ru	pecify Yes or No- o Rican, etc.)  kking  me (First, Middle, Internal Route Number	USA  14. Race - Amel Black, White Specify: B1  16b. Kind of Business/  NA  Maiden Surname)  Bailey  r, City or Town, State, 2	1√√Yes 2 No untry? rican Indian, e, etc. Lack Industry	
To Be Completed by	1. Marital Status  1. Mever Married 2 Married 3. Widowed 4 Divorced  15. Decedent's (Specify only highest Elementary/Secondary (0-12)  Infant  7. Father's Name (First, Middle, Later's Name/Relationship  Boon Bailey  Da. Method of Disposition  1. Burial 2 Cremation 3  4. Donation 5 Other (Specify Control of Specify Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Cont	12. Was Decedent Everage Armed Forces?   1   Yes &   1   No   If Yes, GiveA Year or Dates:	16a. Dece (Give life.) 19b. Maili 612 20b. Place of Dispo cemetery, cre King M	Was Decedent of Hir Yes, specify Cub  1 Yes No  edent's Usual Occup  in Kind of work done  DO NOT use retired  Infant  A Northwo  costion (Name of matory or other place	Hispanic Origin? (Span, Mexican, Puerto Specify: pation during most of world)  18. Mother's Nam Ebony and Number or Ru	pecify Yes or No- o Rican, etc.)  kking  me (First, Middle, Internal Route Number	USA  14. Race - Amel Black, White Specify: B1  16b. Kind of Business/  NA  Maiden Surname)  Bailey  r, City or Town, State, 2	rican Indian, e, etc. Lack Industry	
To Be Completed by	I. Marital Status  1	12. Was Decedent Everage Armed Forces?   1   Yes &   1   No   If Yes, GiveA Year or Dates:	16a. Dece (Give life.) 19b. Maili 612 20b. Place of Dispo cemetery, cre King M	was Decedent of Here, specify Cub  1 Yes 2 No  edent's Usual Occup  in Kind of work done  DO NOT use retired  Infant  Infant  A Northwo  osition (Name of matory or other place	Hispanic Origin? (Span, Mexican, Puerto Specify: pation during most of world)  18. Mother's Nam Ebony and Number or Ru	ne (First, Middle, M ral Route Number Apt. B, J	14. Race - Ame Black, White Specify: B] 16b. Kind of Business/ NA Maiden Surname) Bailey	e, etc.  Lack  Industry  Zip Code)	
9 17 OL 1!	(Specify only highest Elementary/Secondary (0-12) Infant 7. Father's Name (First, Middle, La Don 9a. Informant's Name/Relationship Ebony Bailey 0a. Method of Disposition 1	grade completed)  College (1-4or 5+)  ast)  Matthew  (Type. Print)  Mother  B □ Removal from State cify)	19b. Maili 612 20b. Place of Dispocemetery, cre King M	ing Address (Street  A Northwo  Osition (Name of ematory or other place)	18. Mother's Nam  Ebony  and Number or Ru  ood Dr.,	ne (First, Middle, M ral Route Number Apt. B, J	NA Maiden Surname) Bailey r, City or Town, State, 2	Zip Code)	
17 19 19 20	Don  9a. Informant's Name/Relationship  Ebony Bailey  Da. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spe	Matthew o (Type. Print)  Mother  B □ Removal from State city)	19b. Maili 612 20b. Place of Disport Commetery, cre King M	24 Northwo osition (Name of matory or other place	Ebony and Number or Ru bod Dr.,	ral Route Number	Bailey		
20	Ebony Bailey  a. Method of Disposition  Burial 2 Cremation 3  Donation 5 Other (Spe	Mother  ☐ Removal from State	612 20b. Place of Disponsion Commetery, cre King M	24 Northwo osition (Name of matory or other place	ood Dr.,	Apt. B, 1			
2					9-4		20c. Location - City or Rancallst		
1 1		1) anei	)   2	2. Name and Addre	ess of Facility M	arch F.			
cal Examiner and the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the call the	d								
	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i> _	у		23d. Date of deli Month	ivery Day Year	
ا م	art II. Other significant condition	s contributing to death but no	ot resulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?	
Completed		o pantonea	1 Show	int		24a. Was ar autops perform 1  Yes 2	sy prior to d	topsy findings available completion of cause of	
To Be	<ul> <li>Was case referred to medical examiner?</li> <li>1</li></ul>	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Oth	er.	th <i>(Check only one</i> ome 5 ☐ Reside	e) ence 6 □Other (Spec	cify)	
Certification:	7. Manper of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not determine	be 28e Place of injuny	At home, farm, str	M 1□	ry at k? Yes 2 ⊡No		ow injury occurred reet and Number or Ru n, State)	ral Route Number,	
	9a. Certifier 1 ertifying (Check only one) 2 Medical Ex	Physician: To the best of m caminer: On the basis of exa and manner stated.	amination and/or in	th occurred at the tin estigation, in my o	me, date and place, opinion, death occur	, and due to the carred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)	
₹ 29	bb. Signature and title of certifier  Gatour  D. Name and address of person wh	Tohome			1296	29	9d. Date signed (Month Aug 30, 94 Balki		

			Please Type o								_	
			1- State Registrar	OT IVI	aryland		rtment of I tificate of	Health and <i>Death</i>	Mental Hy			20125
			Decedent's Name (First, Middle, Last)				imouto or	Doutif	2. Date of D		2007	28 25 3. Time of Death
	hysici/ Medio/		Donald W. McCauley						O Q	Da;		05:25 M
	Examin		4a. Facility Name (If not institution, give street and GOOD SAMARITA	NI	40SP	ITAL		or Location of Dea		4c.	. County of Death	
	ineral rector		5. Social Security Number 6. Sex 1 M 2 F	7. Ag	e (In yrs. las.	t birthday) Yrs.	If Under 1 Year Months Days			irth Pay, Year)	9. Birthpl Count Mary	
and	A 1		Usual Residence of Decedent  10a. State 10b. County		10c, City, T	own or Loc	ation					Od. Inside City Limits
Maryl	rf sho fied a	tor	MD		Bal.	timore	2				,	1 Yes 2 No
th the	or 28a e noti	Director	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Coun	try?
ath w	s 23a nust b	ral	1521 Northbourne Road				21239			U.	S.A.	
ter de	ltem iner n	Funeral			Ever in U.S.	13. W	as Decedent of I Yes, specify Cub	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or N rto Rican, etc.)	lo-	14. Race - America Black, White, e	
OUSO hours af	ral", or	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Year o	Give Dates:	944- 946	1	□Yes 2⊠ No	Specify:			Specify: Whi	te
at yiailid ZIZI3-0030 should be filed within 72 hours after death with the Maryland nd Mental Hygiene.	item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade complete			(Give k	ent's Usual Occu	during most of we	orking	16b. K	ind of Business/Ind	ustry
G Z I Z I	than he Me	Junc	Elementary/Secondary (0-12) College	(1-4or 5	i+)		<i>0 NOT use retire</i> facturin	ng Engine	or		Electron-	iaa
e filed	other /ent, t	BeC	17. Father's Name (First, Middle, Last)		i	Hana	rac cur in		me (First, Middle			ics_
2 should be fi	arked atic ev	To B	Arthur Y. McCauley					Ethe	el M. Br	edeka	amp	
VICE 12 sho h and	'Is m		19a. Informant's Name/Relationship (Type. Print)							-	or Town, State, Zip	,
s 1 and 2 of Health a	em 27		Antoinette McCauley/Wif	e	20b. Plac	L521 Ne of Dispos	lorthbou	rne Ŗd.,	Baltimo Date	re C	ity, MD ocation - City or Tox	21239
Pages nent of 1	nt: # ii ny or o		1 Burial 2 ☐ Cremation 3 ☐ Removal from Donation 5 ☐ Other (Specify)	m State	Dura	ĭĕŷ¨Ϋä	atory or other pla	morial 9/	5/2007	Timo	nium, MD	wii, Otato
partment of	Important: If item 2 any injury or other once.		21. Si matur, of Fine I Service Licensee		Garde	3 F1 C				1	uneral Ho	me Inc
<b>0</b> 88.	트등등		Tank to Vagan				.050 York	k Road,	lowson,	MD 2	21204	
Phys	ician		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition		the death. I	Do not ente	r the mode of dyi	ng, such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	dical niner		resulting in death)  Due	to (or as	a consequen	ce of):	-					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	o (or as	a consequen	ce of):						<u></u>
cuted .	ransit	Examiner	that initiated events									
oe exe	cian a	_	resulting in death) Last Due	o (or as a	a consequen	ce of):						
ficate	s the t	edica	d	_								
h certi	nse a	M/ui			pf pregnancy 2  Fetal de						23d. Date of deliver	у
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death.	y me am ached for	Physician/Medica		gnant at	time of deat		Ectopic pregnanc Other <i>(specify)</i> _	y			Month I	Day Year
S that	gned c	by PI	Part II. Other significant conditions contributing to			_		ven in Part I.	23e. Did	tobacco u	use contribute to the	e cause of death?
requir 5	lonid I	ted	MYELODYSPLASTIC	ע	ISOR.	DEK	•		1 🗆	Yes 2	□ No 3 □ Proba	ably 4 Unknown
ie law	nes p	Completed	HYPERTENSION						24a. Was	psy	prior to com	sy findings available pletion of cause of
in it	or, pag		25. Was case referred to medical						1□ Yes	ormed?	death? 1 ☐ Yes	2□No
ysicia	direct	o Be	examiner?	Inpatie	nt 2∐ER/	Outpatient	3□ DOA Oth	104	ath (Check only		6 ☐Other (Specify)	1
5 E 5	neral	T:uc	27. Manner of Death 28a. Da	te of Injur	y 28	b. Time of Injury	28c. Inju Wor	rv at	28d. Describe			,
ttendi death.	the fu	catio	2 Accident investigation	no of iniu	. At home	forms of sec		Yes 2 □ No				
after	d in b	Certification:	4 Homicide determined bu	iding, etc	c. (Specify)	, iaiii, siree	et, factory, office		City or To	(Street an own, State	d Number or Rural )	Houte Number,
ospita hours	aly fille		29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check o	he best of	of my knowle	dge, death	occurred at the ti	me, date and place	e, and due to the	e cause(s)	and manner as sta	ited.
the H	mplete	Medical	and m	anner sta	ted.	and/OF IIIVE	29c. Licens		curred at the time			
5 × 5	2 8		29b. Signature and title of certifier				1	S 000	)		e signed ( <i>Month, E</i>	,
	. \	-	30. Name and address of person who completed ca	use of de	eath (Item 23	a) (Type, P	rint)					
12	11		PRACHI JOG C	1001	DSAI	MAR	1 HATI	HOSPITA	L, BAL	MIT	ORE, MI	D 21239
E	Sta legistra		31. Date filed (Month, Day, Year) 32 SEP 0 4 2007	Registra	ar's Signature	COB.	20					
OHMH 17			10 500 7			9						

2. Date of Death

Month

Dav

28126

11:19 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1XXYes 2 □ No

North Carolina

Year 2007

Baltinge

America

Building

23d. Date of delivery

September 1st 2007

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2D No

Year

Month

Black, White, etc.

White

my

who completed cause of death (Item 23a) (Type, Print)

O O O Court
32. Registrar's Signature

1. Decedent's Name (First, Middle, Last)

**Physician** 

Registrar DHMH 17 Rev 1/2001 30. Name and address

bardie

31. Date filed (Month, Day, Year)

DOUS6632

Randallstown, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State of Maryland / Dep Registrar	partment of Health and Ment ertificate of Death	tal Hygien	°2007 28127
Į.	Dhysisi		1. Decedent's Name (First, Middle, Last)		ate of Death	3. Time of Death
*	Physici /Medio		IVA MASIMORE	$\mathcal{C}$	Month Da	ay 2007 5:25 PM
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b City, Town or Location of Death	40	c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	/) If Under 1 Year   If Under 24 Hrs.   8, D.	ate of Birth	9. Birthplace (State or Foreign
ı.	Director		219-18-9858 1 M 2 XF 81 Yrs.	Months Days Hours Min. (A	Month, Day, Year	1925 Maryland
	pu »		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation		
	fanyla f shoved at	ō	MD Baltimore Pikes			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the N 28a-	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	h with 23a ol st be		26 Village Road	21208	Un	ited States
	ems ?	Funeral		. Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican		14. Race - American Indian, Black, White, etc.
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 CM Married 1 ☐ Yes 2 CM No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates;	1 ☐ Yes 2 XXNo Specify:		Specify: white
21215-0036	2 hou latura Ical E	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b. ł	Kind of Business/Industry
215	ithin 7 ne. nan "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of working  DO NOT use retired)		
	lled w hygier her th	ပ္ပ	10th 17. Father's Name (First, Middle, Last)	Homemaker	A Beindella Beniela	own home
Maryland	12 should be filed v n and Mental Hygie Is marked other t raumatic event, th	To Be	Alvin Long	18. Mother's Name (Firs		dsborough
ary	should and Men s marke umatic	ř	19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ling Address (Street and Number or Rural Rou		
	1 and 2 Health a em 27 Is ther tra		Clarence M. Masimore Husband 26	Village Road Pikesv	ille, M	D 21208
Baltimore,	Pages 1 nent of He int: If Iten iry or oth		LADUIA 2 Licremation 31 Removal from State 1	ematory or other place)		Location - City or Town, State
ᆵ	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.		11	ew Mem. Park Sept. 5	, 2007	Sykesville, MD
Ba	permit. Page Department Important: II any injury or		down B Cally	22. Name and Address of Facility Burrier-Queen Funeral 1212 W. Old Liberty	Road Wi	Crematory PA infield, MD 21784
			23a. P. 1. Inter the disease, or complications that caused the death. Do not enhock or heart failure. List only one cause meach line.	nter the mode of dying, such as cardiac or resp	piratory arrest,	Approximate Interval Between Onset and Death
	Physician / /Medical		In mediate Cause (Final Isease of condition esuition in death)	HRTERY DILPA	98	
	Examiner		Due to (or as a consequence of):			
	D =	ner	if any leading to immediate up to (or as a consequence of):			10
1	nd	Examiner	cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
8760,	cate be extoried obysician and the burial-transit	al E	Due to (or as a consequence of):			
687	ficate g phys	edical	d			
Вох	leath certific attending p	M/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
	ie dea the att	Physician/Me		Other (specify)		Month Day Year
P. O.	that the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I 2	23e Did tobacco	use contribute to the cause of death?
Vital Records,	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as	d by			1  Yes 2	
ဂ္ဂ	aw rei	Completed		2	24a. Was an	24b. Were autopsy findings available
ř		Com			autopsy performed? ☐ Yes 2☑ No	prior to completion of cause of death?  o 1 □ Yes 2 □ No
Ita 	sician: Tr certificate rector, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death  Che		
	Physical direction	٦.	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie  27. Magner of Death 28a. Date of Injury 28b. Time			
o	ding th. : After fune	tion	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	of 28c. Injury at 28d. □ 28d. □ Work?  M 1 □ Yes 2 □ No	Describe how inju	ary occurred
DIVISION OF	al or Attending P s after death. Il Director: After t d in by the funera	Certification:	3 ☐ Suicide 4 ☐ Homicide			and Number or Rural Route Number,
5	ital or irs afte ral Dil	Cert			ity or Town, Stat	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical	29a. Certifier (Check only one)  1 X Certifying Physician: To the best of my knowledge, dea (Check only one)  Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and do nvestigation, in my opinion, death occurred at	ue to the cause(s the time, date an	s) and manner as stated. nd place, and due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
	/		1 trupulable DAD IN	H360)A	0	1-30-2007
	6		30. Name and addless of person who completed cause of death (Item 23a) (Type	, Print)	1	800 20123
	Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature	IT WARD I CONDAIL	span!	11/10 5/133
	Registr		31. Date filed (Month, Day, Year)  SEP 0 4 2007  32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Amend Item 27 per dr., 9871,09/04	107db er	tificate of l	Death	entai riyi	Reg. No. 200	7 28128		
	Physici	an -	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	ath Day Year	3. Time of Death		
	/Medi	cal	4a. Facility Name (If not institution, pive street and number)	15	4h City Town or	Location of Death	AUG.	25, 2007	11:10p M		
)	Examir	ner	Montgomery General Hospital			Location of Death		4c. County of De			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. In	ast birthday)	01ne	If Under 24 Hrs.	8. Date of Birt		rthplace (State or Foreign		
	Director		218-40-9414 1	Yrs.	Months Days	Hours Min.	MAY 4,		rginia		
	nyland how			, Town or Loc	cation				10d. Inside City Limits		
	e Ma Ba-f s tiffed	ctol	Maryland Howard	West F	riendship	p			1 □ Yes 2 🙀 No		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fiutry or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 12440 Frederick Road		10f. Zip Code 2179	94		10g. Citizen of What C	Country?		
	tems	nue	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	3. 13. W	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh			
Maryland 21215-0036	ours afte ral", or i Examir	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		□Yes 2√ No	Specify:			White		
5-0	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa	during most of working	ng	16b. Kind of Business	s/Industry		
121	within ene. than he Me	dmo	Elementary/Secondary (0-12) College (1-4or 5+)		oo not use retired odial	) -		П4	C		
<u>0</u>	i filed I Hygi other ent, ti	e C	17. Father's Name (First, Middle, Last)	Cust	Odiai	18. Mother's Name	(First, Middle,		Service		
<u>'lan</u>	Aenta Aenta rked tic ev	To Be	James Anderson			Ruby	Gollah	on			
lary	2 should and h		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	g Address (Street a	and Number or Rura	l Route Numbe	er, City or Town, State,	Zip Code)		
	and and m 27		Brenda K. Mulder/daughter			Ct. Sykes	sville,	MD 21784			
Baltimore,	Pages 1 nent of H nt: If ite ry or oth				sition (Name of natory or other place emorial Gar	e) dens 8/29	ate /07	20c. Location - City o			
Balti	permit. Departm Importa any Inju once,		21. Signature of Funeral Service Licensee	22. Ha:	Name and Addres	ss of Facility eral Home	' & Chape	7	10-795-1400)		
			23a. Part1. Enter the disease, or complications that caused the death.	P.(	Box 19	5 Sykesvi	11e, M	D 21784 (41	0-795-1400) Approximate		
	Physician	Immediate Cause (Final									
)	/Medical disease or condition resulting in death)  a. Due to (or as a contequence of):										
	Examiner			4	O						
- 6	D #=	iner	Sequentially list conditions, if any, leading to him additional cause. Enter Underlying Cause (Disease or injury that initiated events	ence of):							
	ecute and trans	Examiner									
,00	icate be executed physician and s the burial-transit		Due to (or as a conseque	ince on:							
68760	rtificate ng phys as the	Medical	d								
ŏ	leath certii attending I for use a	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnant	icy				23d. Date of de	livery		
.O. B.	Attending Physician: The law requires that the death certificate be executed or death.  or death.  cropial that this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ Ne 9 ☐ Unknown	Jeath 3□8 ath 5□	Ectopic pregnancy Other (specify)			Month	Day Year		
<u>.</u>	that the led by detac	h Ph	Part II. Other significant conditions contributing to death but not result	ling in the und	derlying cause give	n in Part I.	23e. Did to	bacco use contribute t	o the cause of death?		
Records,	quires n sigr ald be	d b	Breast CA				1 □ Y	es 2∐No 3∐P	robably 4 Unknown		
ပ္ပ	aw require s been sie 2 should b	olete	Ovarion CA		-		24a. Was a	ın 24b. Were a	utopsy findings available		
Ÿ	Physician: The laver this certificate has all director, page 2	Completed					autop: perfor	sy prior to med? death?	completion of cause of		
Vıtal	stan: ertifica ctor, p	BeC	25. Was case referred to medical examiner?			26. Place of Death			s 2 No		
<u> </u>	hysic his ce I direc	10 E	1 Yes 2 No Hospital: Inpatient 2 E	R/Outpatient	3 DOA Othe			ence 6 ☐Other (Spe	ecify)		
פ	ding P		27. Manner of Death 1  Natural 5  Pending  28a. Date of Injury (Month, Day Year) 2	28b. Time of Injury	28c. Injury Work			ow injury occurred			
<u> </u>	ttendi leath. tor; / the fu	cati	2 Accident investigation			′es 2 □ No					
Division or	l or Attend after death Director: ,	Certification:	4 ☐ Homicide determined determined building, etc. (Specify)	e, farm, stree	et, factory, office	28	Bf. Location (S: City or Town	treet and Number or Fi n, State)	ural Route Number,		
	spital ours ours reral		29a. Certifier 1 Certifying Physician: To the best of my know	ledge, death	occurred at the tim	e date and place a	nd due to the o	aueo(s) and manner a	o stated		
	ie Hoi 124 h ie Fur	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	n and/or inve	estigation, in my op	pinion, death occurre	ed at the time, of	late and place, and du	e to the cause(s)		
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in by	Me	29b. Signature and title of certifier A HoSa	ilal.	51 29c. License			9d. Date signed (Mon.	th, Day, Year)		
/			1 A THO MAIS	Th coli	1 000	153643		08/27/0	7		
(	10/		30. Name and address of person who completed cause of death (Item 2		rint)	153643 Obrey	Asa				
7			31. Date filed (Month, Day, Year) 32. Registrar's Signatu	MGH.	C	Juney	IND	>			
	Sta Registra		SFP 0 4 2007	and s				`			

			For State Registrar	State of M	larylan		artment of F rtificate of		Mental Hyg	giene Reg. No. 2 N	n7 :	28129
П	Physic	on	1. Decedent's Name (First, Mid	ldle, Last)					2. Date of Dea	ith	3.	Time of Death
	Physic /Medi		Bridget C.	Pecorino						er ² , 20	Year 07 10	05 A M
	Exami	ner	4a. Facility Name (If not institut		)			r Location of Deal	th	4c. County o	f Death	
		£,	5. Social Security Number	1a Maris	- /1		Time	onium			yland	
- 1	Funeral Director			1 M 2 TF		last birthday) Yrs.	Months Days	Hours Min	. (Month, Day	, Year)	9. Birthplace ( Country)	State or Foreign
			188-09-1245 Usual Residence of Decedent		93			1	Sept. 1	0,1913	Pennsy	Ivania
	how		10a. State 10b. Coun	ty	10c. City	, Town or Lo	cation				10d. In	side City Limits
	e Ma 3a-f s	cto	Maryland	Baltimore			Timo	nium			1	∐Yes 2 <b>X</b> No
	or 24	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wi	nat Country?	
	s 23a nust	eral	2300 Dulaney			2 1.0.1	2		U. S. A.			
	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 □ Never Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □ Married 2 □	12. Was Decedent Armed Forces? arried 1 ☐ Yes 2 📉	?	S. 13. V	Vas Decedent of F f Yes, specify Cub	lispanic Origin? (S an, Mexican, Puei	Specify Yes or No- to Rican, etc.)		<ul> <li>American Inc</li> <li>White, etc.</li> </ul>	lian,
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and pure	e d Hall	a	17. Father's Name (First, Middl	•				18. Mother's Na	me (First, Middle,	Maiden Surname	)	
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<b>6</b> ,05	Health tem 27	11 4	Ann Gross (dau 20a. Method of Disposition	gnter)	20b. P	lace of Dispos	sition (Name of		e, Perry	Hall, Ma 20c. Location - C		
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` <b>.</b> ≣	permit. Pag Department Important: I any Injury o	4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  Bayview Crematory 09/04/2007 Baltimore,  22. Name and Address of Facility Schimunek Funeral Home										ryland
ä	Der Jany		Elam ?	200		9	705 Bela:	ir Road,	Nottingh	nam, Mary	yland 2	1236
	Physician		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final	or complications that cause st only one cause on each li	d the death ine.	n. Do not ente	er the mode of dyir	ng, such as cardia	c or respiratory arr	est,	Appr Inter Onse	oximate val Between et and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as	n Consequ	lence of):					ye	ars
	Examiner										J	
2007	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury	Due to (or as	a consequ	ience of):						
8,0	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С								
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SEPTEMBEI P.O. Box 6	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Medical	IF FEMALE:	23c. If yes, outcome	of pregnar	ncv				001 0-11		
B	death atter	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 🗌 Fetal	death 3	Ectopic pregnancy Other (specify)	1		23d. Date Mont	-	Year
SEP1	t the c by the achec	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown			(-)//					
	ss tha gned I	by P	Part II. Other significant condi	tions contributing to death b	out not resu	lting in the un	derlying cause give	en in Part I.	23e. Did to	oacco use contrib	ute to the cau	se of death?
ord	equire en siç ould b	pa	Diabeta	's Hell	itus				1 □ Y	es 2 <b>/2</b> (No 3	☐ Probably	4 □Unknown
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PECORINO r Vital Rec	sician: The lav certificate has rector, page 2:	Be (	25. Was case referred to medic examiner?						ath (Check only on			
PI	Physician: r this certific ral director, r	P	1 ☐ Yes 2 ☑ 'No			R/Outpatient		4 pk Nursing F	fome 5 ☐ Reside			
ET	Jing I. After funer	ö	27. Manner of Death  1 Natural 5 □ Pend		y Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho	w injury occurred	1	
BRIDGET PECORINO Division or Vital Records,	al or Attending F s after death. Il Director: After d in by the funera	Certification:	3 Suicide 6 Could		urv - At hor	me. farm. stre		Yes 2 □ No	28f Location (St	reet and Number	or Pumi Poud	o Number
BR	after after I Dire d in b	erti	4 ☐ Homicide deter	mined building, et	c. (Specify	)	or, rectory, office		City or Town	n, State)	or nurar nout	e ivumber,
	To the Hospital or Attending Physician: The I within 24 but only after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Medical C	29a. Certifier (Check only one) 2 Medica	ing Physician: To the best	ot examinati	vledge, death ion and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occi	and due to the curred at the time, d	ause(s) and manr ate and place, an	ner as stated. d due to the c	ause(s)
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		-	30. Name and address of perso	n who completed cause of d	leath (Item	23a) Type 5	Print)	161		7	MACK	7 200
	2		ERNESTINE WR	·	. ,	, , , , .	Y VALLEY	ROAD T.	IMONIUM,	MD 2109	3	
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State of Maryland / Department of Health and Mental Hygic	ment of Health and Mental Hygie	tate of Maryland / Departm

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Patrick Carroll Pea		III St	ate of M	aryland	/ Depar	rtment of	Health	and	Mental H	lygiene				77 2013
Physician	Re	gistrar Decedent's Name (First, Midd	le,Last)		Cert	inicate or	Death			2. Date				3. Time of Death
Medical Examine	r	Patrick Ca	rroll							Augu	st 30, 2	007 4c. County o		1920 hrs
*	4.	a. Facility Name (if not institution 666 Todds Lane	on, give street	and number	7)	4	b. City, 10 Rosed		ocation of Deat	.n	Baltimore County		ity	
Funeral	5	Social Security Number	6. Sex	7. A	ge (In yrs. la	st birthday)	If Under		If Under 24Hr		e of Birth(	MM/DD/YYYY)	Foreian	place (State or
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an an annumentation of the Co	-	sual Residence of Decedent  0a, State 10b, County			10c. City.	Town or Location	on							10d. Inside City Limits
T Cow and C	١,		imore			Parkvi								1 Yes 2 X No
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5-0036 led within 72 hours after Hygiene. other than "natural";		7. Father's Name (First, Middle		\	Cm			1	8 Mother's Nar Barba			iden Surname liams	e)	
121 d be fill fental narked event,	Be	Patrick Car			, 51.	19b. Mailin	g Address	(Street	and Number o	r Rural Ro	ute Numb	er City or Toy	vn, State,	, Zip Code)
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygiene Important: If item 27 is marked other than "nan injury or other traumatic event, the Medical Exa	1	20a. Method of Disposition  1 Burial 2 XCrematic	on 3 R	emoval from	0	Place of Dispos crematory or of	her place)			Date / 4 / 20	- 1			Le, Maryland
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Ball permit Depart Impor	ı	21. Signature of Funeral Service	12 X	Yens	2		Burge 3631	e-He Fall	nss-Se s Road	itz F , Bal	unera	re, Mar	ylar	nc. 21211
Physician	+	23a. Part I Enter the disease, failure. List only one caus	or complication	ons that caus	ed the death	. Do not enter	he mode o	of dying,	such as cardia	c or respir	atory arres	st, shock, or he	eart	Approximate Interval Between Onset and Death
/* // dical		Immediate Cause (Final diseas or condition resulting in death)	se a. Gun	shot wou						-	_	_		Death
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6876C certificate anding phys	ian/	23b. Was decedent pregnant in past 12 months?	n the	Live birti Pregnan	h It at time of d		etal death other (Spe		Ectopic pre	gnancy		IVIONITY		bay 100.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tran	Physician/Me	1 Yes 2 No 9							nivon in Part I	12	3e Did to	hacco use con	tribute to	the cause of death?
P.O. es that the igned by	by P	Part II. Other significant con	ditions con	tributing to d	eath but not	resulting in the	underlyin	y cause	given in raiti.			2 🗸 No		obably 4 Unknown
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To t To t Com	Medical	29b. Signature and title of cer	an	d manner sta	1			9c. Licen	se number	_		29d. Date si	igned (N	fonth, Day, Year)
		Talia	11	1	17			0.0	.M.E.			August 3	31, 200	
6		30. Name and address of per	son who com	pleted cause	of de (Ite	em 23a) er 111 Po	enn Stre	et. Ba	Itimore, MD	21201				
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Hygiene	UUI	28	13	ı

State of Maryland / Department of Health and Mental Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Albin Pfeifer September 2007 10:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8319 Still Spring Court Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**™**M 2□F 87 Yrs. 578-62-3398 Director Nov. 28, 1919 Netherlands Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ms 23a or 28a-f show 1 □Yes 2 TING Director Maryland Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8319 Still Spring Court 20817 items 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 10 1 ☐ Yes 2 No Specify Specify: White þ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) International Monetary College (1-4or 5+) than Elementary/Secondary (0-12) Fund Economist marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F Be Albin F. Pfeifer Maria Verhage 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trau once. Hermina Pfeifer/Wife 8319 Still Spring Court, Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State Sept. 3, 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 2007 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service Licensee M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** Rectal Cancer /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 s performe certificate 2 No the Hospital or Attending Physician: director. Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nursing Home 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ျှ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral 1 🕅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D26259 September 2, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8218 Wisconsin Ave., #103, Bethesda, MD 20814 Ava A. Kaufman, M.D., 32 Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** 1:45AM reston ames btember 2 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 501 Roseda mare Franklin timone tospita If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Sex Birthplace (State or Foreign Country) **Funeral** Days 213-28-1668 Hours Min. 13 M 2□ F Yrs. Director macu -20-1931 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1834 Koac 21234 or Iteme 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Maryland 21215-003 3 Widowed 4 Divorced Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene. snt: If Item 27 is marked other then "natural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) driver loverland Dairy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Prestor ္က awrence Preston bome 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cometary, crematory or other place)

Date 20c. Location - City or Town, State 20c. Location - City or T 1834 J Preston Parkville Md Baltimore, 20a. Method of Disposition permit. Pages 1 Department of H Importent: If Ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State □Donation 5 □ Other (Specify) of Furnaral Service Lice 23a. Part1. Enter the disease, or composhock, or heart failure. List only cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final bath **Physician** phalo. disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine o the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has birector, page 2 s autopsy performed? 1 Yes 2 No director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2√ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funerel Director: A completely filled in by the fu investigation 1 Yes 2 No Director: A 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifies 29c. Liçense number 29d. Date signed (Month, Day, Year) completed cause of reath (Item 23a) (Type, Print) 9000 Franklin Square Drive MEUNG 31. Date filed (Month, Day, Year) Aegistrar's Signature 32/ State Registrar

		1- State Registrar Amend #5, perFD, g871, 9/13/07 TT	Certificate of L	Death		3. No.2007	28 33				
hysicia		1. Decedent's Name <i>(First, Middle, Last)</i> Joanne Madelyn Terescik Quarri	_ 1_		2. Date of Death Month 09	Day Year 07	3. Time of Death 6:46 M				
/Medica xamine		4a. Facility Name (If not institution, give street and number)		Location of Death		4c. County of Deat					
		Gilchrist Hospice	Towso			Baltimo					
neral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Gound Months Days Hours Min. (Month, Day, Year)										
ector		201-01-8206 1 1 M 2 M P 98  Usual Residence of Decedent	Yrs. Days		12-05-1	.908	PA				
ta			wn or Location				10d. Inside City Limits				
any Injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	MD Anne Arundel Mi	llersville				1 □ Yes 2 🛣 No				
	Director	10e. Street and Number	10f. Zip Code		10g	g. Citizen of What Co	untry?				
		8243 Mimico South	21108			U.S.A					
	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2\( \) No	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spei in, Mexican, Puerto f	city Yes or No- Rican, etc.)	14. Race - Ame Black, White					
		3X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 □ Yes 2 No	Specify:		Specify: W	hite				
	Completed	15. Decedent's Education 16: (Specify only highest grade completed)	a. Decedent's Usual Occupa	ation during most of working	g 16	6b. Kind of Business/	Industry				
	d E	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired, Seamstress			Berkowitz					
-	ပ္မ	17. Father's Name (First, Middle, Last)	Deamstless	18. Mother's Name	(First, Middle, Ma		tory				
1	To Be	Martin Terescik				n Terescil	ie.				
	_	19a. Informant's Name/Relationship (Type. Print)	b. Mailing Address (Street a								
		Mr. Bernard Quarrick / Son	8243 Mimico		Mille	rsville, l	4D 21108				
			of Disposition (Name of ery, crematory or other place			c. Location - City or	Town, State				
		4 Donation 5 Other (Specify) St. M	lary's Cemete	ry 09-0	7-2007	Uniontown	, PA				
ouce		21. Signature of Funeral Service Licensee	22. Name and Addres	Ave SU	gleton F	uneral & ( nie, MD 21	Cremation				
		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.		-			Approximate Interval Between				
ł		Instruction Course (First	Heart failu				Onset and Death				
ľ		resulting in death)  a. Due to (or as a consequence		<i>'</i>			Years.				
I,	_	Sequentially list conditions, b.									
	Jine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):								
	Examiner	that initiated events resulting in death) Last c	of):								
-	= 1	<b>C</b> d.									
	Pnysician/Medica	IF FEMALE:									
1	lan/	23b. Was decedent pregnant in the past 12 months? 1□Live birth 2 □ Fetal deat				23d. Date of del Month	very Day Year				
	ysic	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			Monar	Day Tour				
		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause give	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death?				
	o D	Hypertension			1 ☐ Yes	2  No 3 Pr	obably 4 Unknown				
1	Completed				24a. Was an	24b. Were au	topsy findings available				
	Ę				autopsy performe 1□ Yes 2	d? death?	completion of cause of				
	ge	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)						
F	0		utpatient 3 DOA Othe	Pr: 4 Nursing Hom	e 5 Residence	ce 6 Other (Spec	city) (bspice				
1			Injury Work	rai ? res 2 □ No	8d. Describe how	injury occurred					
9:	E	3 Suicide 6 Could not be determined 28e. Place of injury ⋅ At home, for			3f. Location (Stree	et and Number or Ru	ral Route Number,				
1	Cell	4 Homicide Setermined building, etc. (Specify)			City or Town, S	State)					
12	cal	29a. Certifier (Check only (Check only and Check only (Check only	e, death occurred at the tim	ne, date and place, a	nd due to the caus	se(s) and manner as	stated.				
18	e e	and manner stated.									
Anding	Med										
Modical Configuration	Ž	Jason Hard MD 00061199 Sept. 3. 2007									
MACHINE				1 ( 7							
((:70)		30. Name and address of person who completed cause of death (Itam 23a)	(Type Print)								
:			(Type, Print) St, Scite								
state stra	e r	30. Name and address of person who completed cause of death (Item 23a)  Jason Bleck, 6565 Noth Charles	(Type Print)								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** EFSF 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death **Examiner** OF MARYLAND MEDICAL CENTER INWERSIT BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 215-22-2734 1**50** M 2□ F Days 80 Oc+ 23, 1926 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Maryland Hartord Count Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be r 1309 21015 Storter United Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 X Yes 2 ☐ if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2□No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: while Completed by 3 ₩ Widowed 4 □ Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimpre Cit 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pe56 Haze ပ 19a. Informant's Name/Relationship (Type. Print) (1) (1) 19-5 htt.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pent Perry Holl Annel Kmy 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Frank Chapel 9/4 2007 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 1 + (rem LM Services - Bel AN 21. Signature of Funeral Service Licensee 3 Nerport Nerport Drive, Forent Hill, MD 21050 23a. Part1. Enter the dit_se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EDEMA LEREBRAL DAY /Medical Due to (or as a consequence of): Examiner DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown LATION, H 1 TYes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No PERLIPIDEMIA 24a. Was an autopsy perform Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🕱 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 200 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 Green St sandra Ruby, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

04

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

d cause of Beath (Item 23a) (Type, Print) 30. Name and address of person who complete FENG DIANA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

M.D

07-06335 Michael Randolph Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

chael Randolph	1-	Sta For State	ate of Maryland	Departi <i>Certifi</i>	ment of icate of	Health an Death	a Meni	lai nygielle	Reg. No	. 29	07 2813
Physician/		e <b>gist</b> rar . Decedent's Name (First, Middle	e,Last)					2. Date of Month	f Death		3. Time of Death 0938 hrs
ed cal Examine		Michael Randa. Facility Name (if not institution		or)	14	b. City, Town, o	Location		ot 16, 20	07 4c. County of Dea	
	4	a. Facility Name (If not institution 5303 Denmore Avenu		51)		Baltimore		. 111			
Funeral	5	Social Security Numberunk	6. Sex 7. A	Age (In yrs. last	birthday)	If Under 1 Yea	_	Min		Fore	irthplace (State <b>o</b> tnk ign
Director			1 X M 2 F	52	Yrs.	World is Day	is Hours	Apr	8, 1	L955 C	Country)
any	_	Sual Residence of Decedent  0a. State 10b. County		10c. City, To	wn or Location	on					10d. Inside City Limits
A		MD			Balti	more					1 Yes 2 No
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th the Maryland  23a or 28a-f sho  notified at once.		5303 Densmore		15 - 110	142 14/2	ŧ .	215	gin? ( Specify Yes	or No-	USA 14 Race - Am	erican Indian, Black,
r death with or items 23		1. Marital Status unk 1 Never Married 2 M	arried Armed Force	ss? unl		es, specify Cuba	n, Mexican	, Puerto Rican, et	c.)	White, etc.	
fter de		3 Widowed 4 Div	1 Yes  vorced If Yes, Give Year or Dates:	2 No		Yes 2 X N				Specify:	black
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36 in,72 l	ald .	Elementary/Secondary (0-12)	College (1-4 o	or 5+)					41 1	- 1000	
215-0036 be filed within, 7 hal Hygiene. Red other than ent, the Medica	⊏ L	17. Father's Name (First, Middle				unk	18.Mothe	r's Name (First, M	iddle, Maid	den Surname)	unk
21215-0 uld be filed v Mental Hygi marked oth			(T. Dist)		10h Mailine	Address /Str.	oot and Nu	mber or Rural Rou	ite Number	r, City or Town, St	ate. Zip Code)
0	2	19a. Informant's Name/Relations O.C.M.E.	inip (Type, Print)					Baltimor	e, MI	21201	
e, MD I and 2 sho Health and item 27 is		20a. Method of Disposition				ition (Name of o		Date	20	Oc. Location - City	or Town, State
MOF Pages   ent of nt: If	ı,	1 Burial 2 Cremation 4 Donation 5 X Other S		State							
Baltimore, MD permit. Pages 1 and 2 shr Department of Health and Important: If item 27 injury or other traumarinjury or other traumarinjury or other traumarini.	T	21. Signal to of the angle of the			2 N	are And Addre	ss of Facili Comy	board, 65	5 W.	Baltimo	re Street
	4	23a. Parl. Enter the disease,	r complications that cau	sed the death. D	I Ba	iltimore	· MD	21201			Approximate Interval
Physician /Medical		failur. List only one cause Immediate Cause (Final disease	e on each line.								Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a co					al. la l			
	۱.	Sequentially list conditions, if any, leading to immediate	b	onsequence of):							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to /or oc o o	onsequence of):							
cecuted n and rtansit	Ĕ	events resulting in death) Last	d.			No.					
O, e be exect ysician an burial - tr	edical	XUNPENDED	☐ A#5NBED27	perME,g8	71, 9/7/	/07_TT					
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Š	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes, ou	tcome of pregna	ancy	etal death	3 Ector	oic pregnancy		23d. Date of deli Month	very Day Year
Box 6876( c death certificate the attending phy cd for use as the b	iciar	past 12 months?	4 Pregnar	nt at time of dea	2	ther (Specify)					
Bo he deat	Physician/M	Part II. Other significant cond	nknown 9 Unknow		sulting in the	underlying caus	e given in l	Part I. 23	e. Did toba	acco use contribut	e to the cause of death?
cords, P.O. B aw requires that the d has been signed by the 2 should be detached		Part II. Other significant cond	mons contributing to a		g			1	Yes	2 No 3	Probably 4 🗸 Unknown
rds, require been si	Completed by							24	a. Was an autopsy	prior	e autopsy findings available to completion of cause of
ecor ne law te has l	틸			· · · · · · · · · · · · · · · · · · ·				1	perform Yes 2	ed? deat	h? Yes 2 No
tal Reco	Be C	25. Was case referred to medic				26.PI		th (Check only one	-		100
Vita		examiner?  1 ✓ Yes 2 No			ER/Outpatier 28b. Time of		Other	Nursing Home		esidence 6 🗸 C w injury occurred	other: Scene
n of iding Pl h. : After e funeral	io ii	27. Manner of Death  1 X Natural 5 Pe	28a. Date o (Month, I ending	Day,Year)	200. 11110 01	1	Yes 2			. ,	
Division of Vital Records, la lor Attending Physician: The law requirers after death.  The law requirers after this certificate has been sind in by the funeral director, page 2 should be in by the funeral director, page 2 should be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be	ficat	2 Accident Inv	entigation	of Injury - At ho	me, farm, str	eet, factory, offic	e building,		cation (Str Town, Sta		r Rural Route Number, City
Div	Certification:	4 Homicide de	termined (Specify)				_				
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate! completely filled in by the funeral director, page		29a. Certifier 1 Certifying one) Medical Ex	Physician: To the best kaminer:On the basis of	of my knowledg	e, death occ	urred at the time	, date and nion, death	place, and due to occurred at the tir	the cause( ne, date ar	(s) and manner as nd place, and due	stated. to the cause(s)
To th within To th compl	Medical	29b. Signature and title of certi	and manner sta	ated.			ense numb				(Month, Day, Year)
	=	Qui	IZ.			0.	C.M.E.			August 17, 26	007
		30. Name and address of person			23a)			ID 04054			
		Ana Rubio MD. A	ssistant Medical E	xaminer	111 Penn	Street, Balt	more, M	D 21201			
Sta	ate		ar) 32. Reg	gistrar's Signatu	ire	Inache s					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Margaret Dora Robertson 4c. County of Death 4a Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Koseo tospita Mone -ranklin If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2 € F Maryland 219-18-4563 83 Jan. 24,1924 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Rosedale Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21237 4858 Bright-Leaf Court 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Yes 2 🕱 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Sheben William Vogel 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4858 Bright-Leaf Court Rosedale, Maryland 21237 Edward T. Robertson, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith Cem. 9/1/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 7922 Wise Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): LIVIY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

/Medical Examiner be executed Box 687605 P.O. Division or Vital Records, or Attending Physician:

and burial-trai physician the for use as attending the signed by t peen has page 2 certificate After this death. To the Funeral Director: completely filled in by the within 24 hours after To the Hospital

**Physician** /Medical

**Examiner** 

Funeral

Director

28a-f show

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permit. Pages 1 and 2 should be 1
Department of Health and Mental I
Important: If item 27 is marked of

Important: If it any injury or o

**Physician** 

Examine

Physician/Medical

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Completed

Be

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Certification:

Medical

(Check only one)

29b. Signature and title of certifier

Maryland 21215-0036

Baltimore,

Director

Funeral

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Completed

other traumatic event, the Medical Examiner must be notified at

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D37612

08-29-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 FRANKLIN Square ALabRash DRIVE DRMohamad

31. Date filed (Month, Day, Year) 32/Begistrar's Signature

**ORIGINAL** 

DHMH 17 Fev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Anthony Saunders	1	- For State	Sta	ate of Maryla		irtment of <i>tificate of</i>		nd Mental H		leg. No.	200	7 2	2814			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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DeQuincey	Antonio	Smith
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		i- For State Registrar	Certi	ficate of Dea	th	Reg.	No.	
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2 hours aft "natural" I Examine	eted by	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	or Dates:	6a. Decedent's Usua	al Occupation (Give kind of orking life. DO NOT use ret	work done (1	16b. Kind of Business/	Industry
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	Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnat 1 Live birth 4 Pregnant at time of deal	2 Fetal dea		ancy	23d. Date of deliver Month	ry Day Year
.O. Box 687 that the death certifi ned by the attending detached for use as i	Physician	1 Yes 2 No 9 Unknow	g Unknown	J Other (O				
r, P.O. ires that the signed by the detached	by	Part II. Other significant conditions	contributing to death but not res	sulting in the underly	ing cause given in Part I.		pacco use contribute to 2 ✓ No 3 Pro	o the cause of death?
of Vital Records, ng Physician: The law requir ufter this certificate has been s meral director, page 2 should b	ompleted			<del> </del>		24a. Was al autops perform	y prior to ned? death?	utopsy findings available completion of cause of
Vital Recolysician: The law his certificate has director, page 2 si	ပ	25. Was case referred to medical			26.Place of Death (Check		. No I V	es z no
Vita Physicia r this ce al direc	To B	examiner? 1 ✓ Yes 2 No		ER/Outpatient 3	DOA Other Nurs  28c. Injury at Work?		Residence 6 Othe	er: Scene
on of ending Phath.  or: After the funeral		27. Manner of Death  1 Natural 5 Pending	FOUND:	28b. Time of Injury FOUND: 2046 hrs	1 Yes 2 ✓ No	Subject shot	, ,	
Division ital or Attendir irs after death. ral Director: A	Certification:	2 Accident Investiga 3 Suicide 6 Could no determin	28e. Place of Injury - At hor	me, farm, street, facto	ory, office building, etc.	or Town, St		tural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier 1 Certifying Physi	cian: To the best of my knowledge er:On the basis of examination and and manner, stated.	e, death occurred at	the time, date and place, an my opinion, death occurred	nd due to the cause at the time, date a	e(s) and manner as sta and place, and due to t	ated. he cause(s)
F . 8 6 0	ğ	29b. Signature and title of certifier	and manifer stated.		29c. License number		29d. Date signed (M August 29, 200	-
4		30. Name and ad ress of person who	o completed cause of death (Item 2	23a)	O.C.M.E.		August 28, 200	
<u>`</u>		Zabiullah Ali, M.D. Ass	sistant Medical Examiner	111 Penn Str	eet, Baltimore, MD 2		A4442	
S Regis	tate trar	31. Date filed (Month, Day, Year) 2	32. Registrar's Signatur	e			OCME	

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the I within 2.

State Registrar

completely

Medical

29a, Certifier (Check only one)

29b. Signature and title of certifier

JOGINDER

31. Date filed (Month, Day, Year) SEP 04

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EL H



Mehla M.D

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 41410

29d. Date signed (Month, Day, Year)

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MARYLAND 21204

2001.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-06627 State of Maryland / Department of Health and Mental Hygiene Matthew Sivells 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day August 26, 2007 1416 hrs Sivells Medical Examiner Matthew 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) NA **Baltimore** Johns Hopkins Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 6. Sex 5. Social Security Number **Funeral** Hours Months Days Country) Director 6-18-1981 Md. 1 X M 2 Yrs 218-02-5663 26 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No Baltimore NA or 28a-f show Md. or items 23a or 28a-f sho must be notified at once. Director 10q, Citizen of What Country 10f. Zip Code 10e. Street and Number 21206 USA 6104 Walther Avenue 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes 2 X No Specify: Black If Yes, Give Year Yes 2 X No specify: Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after
Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
The propriett I litem 27 is marked other than "matural", of highly or other traumatic event, the Medical Examiner. Divorced Widowed þ 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Unemployed NA 11th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sivells Michelle Anderson Be James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 21206 6104 Walther Ave., Baltimore, Md. Michelle Sivells Knox 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition X Burial 2 Cremation 3 crematory or other place) 8-31-07 Lansdowne, Md. Zion Cem. Mt. Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses March F.H. East 21202 1101 E. North Ave., Baltimore, Md. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Death /Madical a. Multiple Gunshot Wounds Immediate Cause (Final disease amine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED UNPENDED attending physician or use as the burial The law requires that the death certificate be Box 68760, 23d. Date of delivery IE FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 ✓ No 3 Probably 4 Unknown ۾ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? has performed? 2 No Yes 2 1 🗸 Yes certificate 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: DOA Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 Inpatient 2 this 1 🗸 Yes ပ္ 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27 Manner of Death Medical Certification: Subject shot 1351 hrs 1 Yes 2 V No Natural

To the Hospital or Attending Physician: Division of Vital Funeral Director: tely filled in by the hours after death. 24 To the F

28a. Date of Injury (Month, Day Year) Aug 26, 2007 Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) 1900 Cecil Avenue, Baltimore, MD Suicide determined (Specify) Street 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 27, 2007

30. Name and address of person who completed cause of death (Item 23a)

Signature and title of certifie

111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner

32. Registrar's Signature

ME SEL

31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day August 31 2007 4:15 Charles Norman Schultheis Sr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Stella Maris Hospice Timonium Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min 1**X** M 2□ F 85 216-16-2101 Feb. 3, 1922 Maryland Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 X No MD Baltimore Lutherville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8400 Ellison Road 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1942-45 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Comptroller Finance 18. Mother's Name (First, Middle, Majden Surname) 17. Father's Name (First, Middle, Last) William George Schultheis Minnie E. Schreiner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles N. Schultheis Jr./Son 7 Salthill Court, Timonium, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hilltop Serv. Corp. 09/4/2007 Towson, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee Towson, MD 21204 1050 York Rd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) esophagea Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? res 2 No 1□ Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HO5 pice 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No M 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

Box P.O. Division or Vital Records, Hospital or Attending Physician:

State

within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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1 and 2 should be filed withi Health and Mental Hygiene.

Marýland 21215-00

Baltimore.

Funeral Director

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Examiner

Physician/Medical

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Certification: To

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohm (Ind 230C) Dulaney Valley

32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 30, 12:31 A M Rose Dorothy Srebroski August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center for Hospice Care Towson 8. Date of Birth (Month, Day, Ye Aug. 18, 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Many 1 and 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year 1917 Months 1 □ M 2 👿 F Days 219-07-5254 90 Aug. Mary land Director Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3982 Norrisville Road 21084 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: 3 ☐ Widowed 4 💆 Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pediatrics Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Schmid Rose Dorothy Ege 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leo J. Muraro, Jr. 1700 Gatekeeper Drive; Finksburg, MD 21048 son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other ( 3 ☐Removal from State Sacred Heart of Jesus 9/1/07 Baltimore, MD Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest to on each line. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and a betached for use as the burial-transit Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an perfor 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence Other (Specify 105P1 CE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of after death. I Director: After t 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral L Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certif DANIEUE DOBERNEAN, MD BALTIMORE, MD 21204 person who completed cause of death (Item 23a) (Type, Print) SUITE 216 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

			1 - State of Ma Registrar	ryland / Depa <i>Cer</i>	artment of H Tificate of I		lental Hygi	ene g. No. 2007	28147
	Physici	an	Decedent's Name (First, Middle, Last)     Carl Edward Shaff	or			Date of Death     Month		3. Time of Death
	/Medic	cal	4a. Facility Name (If not institution, give street and number)	<u>ET</u>	4h City Town or	Location of Death	Sept.	1 2007 4c. County of Deat	2:30 PM M
k.	Examin	ier	Lorien Skilled Rehab. Ce					Carro	
	Funeral Director		5. Social Security Number $168-14-2209 \hspace{1.5cm} \text{6. Sex} \hspace{1.5cm} 7. \hspace{0.5cm} \text{Age}$	(In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 22,	9. Birt	hplace (State or Foreign untry) Δ
-	0		Usual Residence of Decedent	10. 67. 7				1.7	
	arylar show	<u>-</u>	10a. State 10b. County MD Carrol.1	10c. City, Town or Loc  M+	Airy				10d. Inside City Limits 1 □ Yes 2 X No
	the M 28a-f otifie	Director	10e. Street and Number	1100	10f. Zip Code		10	lg. Citizen of What Co	
3	n with		2406 Braddock Road			1771		United S	•
	ems 2	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame Black, White	
9	be filed within 72 hours after death with the Maryland tatal Hygiene.  tatal Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 □ Never Married 2 □ Married   17/20XYes 2 □ No 11/40	0	I∐Yes 2∐XNo	Specify:	,	2 16	White
2-003p	tural'		15. Decedent's Education	16a, Deced	lent's Usual Occup	ation	1	6b. Kind of Business/	
C12	within 72 ene. than "nat he Medica	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+ 5		kind of work done of OO NOT use retired	during most of work f)	ring		ŕ
7	e filed wit al Hygien other th vent, the	Con			urchasing			Thiokal	Corp.
land		To Be	17. Father's Name (First, Middle, Last)  Karl A. Shaffer			Paulin	e (First, Middle, M ⊖	laiden Surname)	
Mary	s 1 and 2 should if Health and Mer Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type. Print)  David Shaffer Son		g Address (Street a Braddock		t. Airy,	City or Town, State, 2 MD 21771	Zip Code)
ě.		111 - 21	20a. Method of Disposition	20b. Place of Dispos	sition (Name of natory or other place	e)	Date 2	20c. Location - City or	Town, State
	Pages ment of lant: If its		1 \ Burial 2 □ Cremation 3 □ Removal from State 4 □ Conation 5 □ Other (Specify)		s Union (		. 6, 200	7 Seven V	alleys PA
Balt	permit. Page Department of important: If any injury or once.		21. Signature of Funeral Service Licensee	Bi	Name and Address urrier-Qu 1212 W. (	ss of Facility 1een Fune Old Liber	ral Home tv Road	& Cremato Sykesvill	ry, PA e, MD 21784
			23a art1 Inter the disease, or complications the baused to shoot, or heart failure. List only one cause in said line	he death. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
F	hysician /Medical		Imned le Cause (Final dise e or condition resulting in death)		ulure	with	Ta, our	e 70 -	Onset and Death
E	Examiner		D'e to (or as a	consequent of):					MO;
		ner	Saquentian) het conditions, if any, leading to immediate cause. Enter Underlying	consequence of):	Q1.	blican	_		
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200	g phys as the	edical	d 3. W	109/	4 / 1 - /	7			7
ž į	th cert ending	an/M	IF FEMALE: 23b. Was decedent pregnant 1□Live birth		Ectopic pregnancy	,		23d. Date of del	
	w requires that the death certin been signed by the attending should be detached for use as	Physician/Me	in the past 12 months?  1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at t 9 ☐ Unknown		Other (specify)			Month	Day Year
ν, Τ	requires that the een signed by the nould be detache	by Pt	Part II. Other significant conditions contributing to death but			en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
cords,	require sen sij	ted	Hypertension, arem	19, ans	ciety		1 ☐ Yes	s 2 No 3 Pr	obably 4 Unknown
ပ္က	e law has b	Completed	depression				24a. Was an autopsy perform	prior to o	topsy findings available completion of cause of
	sictan: The law certificate has t irector, page 2 s		OF Was soon referred to modical				1□ Yes 2	No 1 □ Yes	2 No
<u> </u>	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No  Hospital: 1 ☐ Inpatien	t 2 ☐ ER/Outpatien	t 3 DOA Othe	er.	h <i>(Check only one</i>	nce 6 □Other (Spe	cify)
		J: L	27. Manner of Death 1 ☑ Natural 5 □ Pending (Month, Day		28c. Injur Worl		28d. Describe how		·y)
SION	tendi leath. tor: A the fu	catio	2 Accident investigation	At home form str		Yes 2 □ No	201   11 /21		
	al or Al	ertification:	4 Homicide determined building, etc.	y - At home, farm, stre (Specify)	вет, тастогу, опісе		City or Town,	eet and Number or Ru . State)	Iral Houte Number,
	e the Hospira or Attending Physician: flini 24 hours after death.  of the Funeral Director: After this certification ompletely filled in by the funeral director,	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of 2 Medical Examiner: On the basis of and many e state.	examination and/or inv					
-	Withir Comp	Me	29b. Signature and title of cortifier	111.11	29c. License	- 11 - 11		d. Date signed (Mont.	
(	= + ,		30. Name and address of person who completed cause of de-	ath (liem 3a)/Tuna	Print) 1	414	/	Sept 3,	2001
1	277		31. Date filed (Month, Day, Year) 32. Registrar		e tre,	D-1, H	led ERK	ck, mel.	2170/
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State of Maryland / Department of Health and Mental Hygiene 28148 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Ί, September 2007 13:55 Lisa S. Stone /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 22, 1954 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖾 F 216-64-3734 53 June Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show iral", or items 23a or 28a-f shov Examiner must be notified at 1 XIYes 2 ☐ No Director Maryland | Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20851 112 Evans Street United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ð Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) is marked other than Independent Consultant Vice President permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hyg
Important: If item 27 is marked other
any injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul K. Schork Margaret Watkins ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 Lamp Post Lane, Hershey, Pennsylvania 17033 John S. Schork / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery : 6**,** 2007 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serve License Robert A. Pumphrey Funeral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a, Part1. Enter the dise shock, or heart failu Immediate Cause (Final Cardiac **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypotunsian Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Cisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Cirrhosis law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Encephalopathy Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s performed? Yes 2 No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury 27. Manner of Death 1 ☑ Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier HAMID Majdi MD DØ65787 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hamid Majdi, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850 a2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		1 - For State Registrar	State of Maryland / D	Department of Health and Certificate of Death	Mental Hygiene	107 28149
Physi	ician	1. Decedent's Name (First, Middle, Last)	rtha Symbor		2. Date of Death  ( Month Day	3. Time of Death
/Med Exam	dical niner	4. 5. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20		4b. City, Town, or Location of Deat	September d 4c. Court	2007 12:40PM
		5. Social Security Number 6. Sex	Pral Huspita 7. Age (Il yrs. last birt	Hoday) If Under 1 Year   If Under 24 Hrs.	J 8. Date of Birth	Birthplace (State or Foreign
Funera Directo		216–99–2080	00	Yrs. Months Days Hours Min.	March, 20 1918	Country) PA
yland how at		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town			10d. Inside City Limits
the Mar 28a-f sl	Director	MD  10e. Street and Number	Balt	imore	10s Citizen e	1 X Yes 2 □ No f What Country?
th with 23a or 1st be n	<u> </u>	524 North Charle	es Street	21201	Tog. Citizen o	USA
Datifiliore, Intal yialing Z.I.Z.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at	hv Fimeral	3 Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 X No Specify:	to Rican, etc.) BI	ace - American Indian, ack, White, etc. ify: White
n 72 ho "natur edical I	Peter	15. Decedent's Educa (Specify only highest grade	ation 16a.	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	16b. Kind of	Business/Industry
ZIZ Ziene. er than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Manicurist	I	uty Shop
d be file antal Hy red oth	å	17. Father's Name ( <i>First, Middle, Last)</i>	Vest	18. Mother's Nar <b>Emm</b>	ne (First, Middle, Maiden Surna a I. Bittner	ame)
and 2 should be filed within eath and Mental Hygiene.  To smarked other than 'n 27 is marked other than 'n traumatic event, the Me	F	19a. Informant's Name/Relationship (Type	e. Print) 19b.	Mailing Address (Street and Number or Ru	ural Route Number, City or Tow	n, State, Zip Code) tsville, MD 21536
s 1 and f Health item 27 other tr		20a. Method of Disposition	20b. Place of	Disposition (Name of y, crematory or other place)	-	ı - City or Town, State
mit. Pages partment of I portant: If ite		1 ☐ Burial 2 ☐ Cremation 3 X Re 4 ☐ Donation 5 ☐ Other (Specify)	Union	Cemetery 09/	06/2007 Meye	rsdale, PA
permit. Departr	ouce	21. Signature of Funeral Service Licenses	1. Marshall	22. Name and Address of Facility Charles L. Steven: 1501 East Fort Av		
		shock, or heart failure. List only one	ations that caused the death. Do no cause on each line.	not enter the mode of dying, such as cardia		Approximate Interval Between Onset and Death
Physiciai /Medica	_	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of	Hrrythmia		
Examine		Sequentially list conditions, b.	Pleyral Ef	fusion		
cuted nd ransit	Examiner	Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Anasarca			
ficate be executed physician and sthe burial-transit			Due to (or as a consequence of	of):		
ertificate ng phys	Medical	d.				
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		oate of delivery Month Day Year
equires that een signed b	2	r art ii. Other significant conditions cond	ributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use co 1 ☐ Yes 2 ☐ No	ntribute to the cause of death? 3 □ Probably 4 □ Onknown
The la	Completed				autopsy performed? 1□ Yes 2□ Yo	b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
nysiclar nis certii directo	o Be	examiner?	spital: 1 ☑Inpatient 2 ☐ ER/Out	Other:	ath <i>(Check only one)</i> Iome 5□ Residence 6□0	ther (Specify)
	Certification: T	27. Man of Death  1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. T	ime of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how injury occu	urred
al or Att after de Direct	ertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (Street and Nun City or Town, State)	nber or Rural Route Number,
To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral	edical C		clan: To the best of my knowledge er: On the basis of examination and and manner stated.	, death occurred at the time, date and place d/or investigation, in my opinion, death occu	e, and due to the cause(s) and r urred at the time, date and place	manner as stated. e, and due to the cause(s)
To th To th	Me	29b. Signature and little of certifier	WUSH, MAD	29c. License number	29d. Date sign	ned (Month, Day, Year)
1		30. Name and address of person who com	ipleted cause of death (Item 23a) (	Type, Print)	' Vepte	mber 2, 2001
0	State	31. Date filed (Month, Day, Year)	32. Resistrar's Signature.	% Maryland C	ieneral Hospi	tal
Regis		SEP 0 4 2	107 Magnes 15	April 1		

07-06736 Tina Schuyler

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 28150

ma concepto.		I- For State Certificate Registrar	of Death	Reg	. No.	
Physician	1/	Decedent's Name (First, Middle,Last)		2. Date of Death Month	Day Year	3. Time of Death 1206 hrs
Medical Examine		Tina Schuyler  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	August 30, :	4c. County of Deat	
		Good Samaritan Hospital	Baltimore			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24H Months Days Hours M		(MM/DD/YYYY) 9. B Fore	ign
Director		217-84-5169 1 M XXF 39	Yrs. Months Days Hours M	7/9/6	08 C	ountry) MD
		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or	ocation			10d. Inside City Limits
ow any			Parkville			1 Yes 2 XNo
Maryland 28a-f show	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Co	untry?
after death with the Maryland alt", or items 23a or 28a-f sho iner must be notified at once.	2	1749 Wycliff Avenue	21234		US	SA
with ms 23;	<u>e</u>	A	B. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer		14. Race - Ame White, etc.	erican Indian, Black,
or ite	Funeral	Never Married 2 Married 1 Yes 2 X No			Specify:	white
8 = E	≧-	or Dates:	1 Yes 2 X No specify:	of work done	16b. Kind of Business	
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5-0036 ed within 72 tygiene. other than "	Completed	9 0	Never Worked			N/A
5-0 iled w Hygie d othe		17. Father's Name (First, Middle, Last)		me (First, Middle, Mi e Marie K		
	e Be	Herman C. Russell  19a. Informant's Name/Relationship (Type, Print)  19b. N	Mailing Address (Street and Number of		_	ite, Zip Code)
MD 2 shou th and it and it are inmatic	۱		1 A. Smithy Squar		Burnie MD :	21061
2 8 5		20a. Method of Disposition	or other preceding to cometery. 9	-8 ^D 07	Balto.	or Town, State
MOF Pages ent of int: 11	-1	4 Donation 5 Other Specify:	even Cemetery 9	/ <del>6/</del> 07	Glen Bur	nie MD
Baltimore, permit. Pages 1 a Department of He Important. If ite injury or other ti	T	21. Signature of Funeral Service Licensee Victor Doda	22. Name and Address of Facility Charles L. Steven	s Funeral	Home. In	C.
	4	23a. Part I. Enter the disease, or complications that caused the death. Do not e	Charles L. Steven 1501 E. Fort Aven	ue. Balti	more MD 2	1230 Approximate Interval
Physician 'Medical	- 1	failure. List only one cause on each line.	The fire mode of dying, sacinate cardia	- 4		Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death)  a. Asthma  Due to (or as a consequence of):				
		Sequentially list conditions, b				
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d sit	xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		<u> </u>		
xecuted n and - transit		d.  X UNPENDED AMENDED 0872 1	0/5/05 00	<b></b>		
60, ate be e ohysicia	Medical	#23a,27,perME,g8/2, 1  IF FEMALE: 23c. If yes, outcome of pregnancy	0/5/07 TT <b>20a-c per</b>	th g8/2	23d. Date of deliv	ery
3876 rtificat ling ph	- 1	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pre	gnancy	Month	Day Year
Box 687  e death certific  the attending I  ed for use as t	sician	4 Pregnant at time of death 5 Yes 2 ✓ No 9 Unknown 9 Unknown	Other (Specify)			
D. B. the de by the ached i		Part II. Other significant conditions contributing to death but not resulting it	n the underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
, P.O. res that th signed by				1 Yes	2 <b>✓</b> No 3 P	robably 4 Unknown
ords,	ete			24a. Was a		autopsy findings available to completion of cause of
eco he law ate has	Completed			perfor 1 ✓ Yes		
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safter death.  The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	Be C	25. Was case referred to medical	26.Place of Death (Che	eck only one)		
Vita hysici	인.	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 VER/Out			Residence 6 Ot	her:
n of ding Ph	ä	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Til	ne of Injury   28c. Injury at Work?	28d. Describe i	low figury occurred	
Siol Atten r death ector: by the	Cati	2 Accident Investigation 28e Place of Injury - At home, farm	n, street, factory, office building, etc.	28f. Location (S	Street and Number or	Rural Route Number, City
Division Hospital or Attent 24 hours after death Funeral Director:	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, S	tate)	
		29a. Certifier 1 Certifying Physician: To the bear of my knowledge, death	occurred at the time, date and place,	and due to the caus	e(s) and manner as s	stated.
To the within 2 To the complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or invending the stated.		ed at the time, date		
	Š	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (	
		U mL	O.O.IVI.E.		1	
		Name and address of person who completed cause of death (Item 23a)     David Fowler M.D. Chief Medical Examiner 111 Personal Complex Section 23 (Item 23a)	nn Street, Baltimore, MD 212	201		
Sta	ate	31. Date filed (Month, Day, Year) 32. Ref. strar's Signature	la v.			
Registi		SEP 0 4 2007   Blesser D.	grava			
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			State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And State of Maryland And		rtment of He tificate of D		lental Hyg	iene 20	07	28151				
-	5 35		1. Decedent's Name (First, Middle, Last)				2. Date of Deat			3. Time of Death				
П	Physici /Medic		Ronald Eugene Tiller				Month Aug 16	, 2007	Year	11:30 A M				
7	Examin		4a Facility Name (If not institution, give street and number)  Baltimore Washington Medical Center  2605 Chapel Lake Dr. #11/i		4b. Cify Town, or l Glen Burnie Gambrillo	ocation of Death		4c. Count	y of Death					
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec 24,	Year) 1932	9. Birthr	place (State or Foreign htry)				
	yland		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Lo	cation				1	I0d. Inside City Limits				
	the Mar 28a-f sh notified	Director	MD Anne Arundel Gambri  10e. Street and Number	11s	10f. Zip Code		1	0g. Citizen of	What Cour	1 ☐ Yes 2XXNo				
	3a or				21054			USA						
	death ms 2: mus	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of His	panic Origin? (Spe	ecify Yes or No-	14. Ra	ce - Americ					
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	Armed Forces?  1 ☐ Ne ver Married 2 ☐ Married  1 ☐ Ne ver Married 2 ☐ Married  1 ☐ My es 2 ☐ No If Yes, Give Year or Dates:		f Yes, specify Cubar I□Yes 2KXNo	Specify:	Hican, etc.)	Speci	rk, White,					
200	72 ho natur lical E	sted	15. Decedent's Education (Specify only highest grade completed)		lent's Usual Occupa kind of work done do			16b. Kind of E	Business/In	dustry				
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7	iled w lygiel ther ti		12 4 17. Father's Name (First, Middle, Last)	ASSU	ırity Claims	18. Mother's Name			rance me}					
anc	d be f ental F red of	9 Be	Samuel Tiller			Faye	, (1 ,101, 1111010, 1		,,,,,,					
Maryland 21215-0036	d 2 should be file th and Mental H 7 Is marked oth traumatic even	은		19b. Mailin	g Address (Street a		al Route Number	; City or Town	n, State, Zip	Code)				
	and 2 ealth a n 27 Is		Steven Tiller Son	820 No	orthfield La	ne, Crowns	ville, MD	21032						
Baltimore,	of He		20a. Method of Disposition 1 □ Burial 2N⊠Cremation 3 □ Removal from State	e of Dispos etery, crem	sition (Name of natory or other place		Date	20c. Location	- City or T	own, State				
E H	Pag tment tant: I		4 □ Donation 5 □ Other (Specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		ematory		0, 2007	Baltim	ore, M	D				
Bal	permit. Pages 1 Department of I Important: If Ite any Injury or ot		21. Signature Societies 22. Name and Address of Facility Fink Funeral Home, P.A.  K. Gregory Fink M01148 426 Crain Hwy S., Glen Burnie, MD 21061											
r			23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition)  CARDIO (VLMCVARY)  ARLEST											
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8760,	icate be exeputed physician and s the burial-transit	dical Ex	resulting in death) Last  Due to (or as a consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the conseq	ice of): をてと	5 MEL	LITUS	5							
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	quires that n signed by	by	Part II. Other significant conditions contributing to death but not resulting	ng in the ur	nderlying cause give	n in Part I.	23e. Did to		ntribute to t	the cause of death?				
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/ita	iclan: Th certificate ector, pag	Be	25. Was case referred to medical examiner?		Lou	26. Place of Deat								
Or	Physiclan: - this certifical director,	은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 XER	R/Outpatien 8b. Time of	t 3 DOA Othe	4 Li Nursing Ho	me 5 Resid			f(y)				
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<b>Division or Vital</b>	or Attenative death	Certification:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home building, etc. (Specify)	e, farm, str			28f. Location (S City or Tow		nber or Rur	al Route Number,				
_	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Ce	29a. Certifier (Check only one)  1 CertifyIng Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.											
	To the To the Co the Comple	Med	, and market states		29c. License	number	2	9d. Date sign	ed (Month	, Day, Year)				
	C>F0		> s mermali	1	D29:	748		8-17	1 - 8	2007				
	10		30. Name and address of person who completed cause of death (Item 23 ACLE MAIVEJWATA, M).  31. Date filed (Month, Day, Year)  SEP 0 4 2007	3a) (Type,	Print) CFAIN	tany	3.E 60	ENBUR	RNE	MD 2106/				
	Sta Regist		31. Date filed (Month, Day, Year) 32. Refistrar's Signature SEP 0 4 2007	& A	perte									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 21:46 P M Richard Taylor AUGUST 200) 29 /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE SAINT AGNES MOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 X M 2 ☐ F **Funeral** Months Days 163-05-9535 97 June 21, 1910 Maryland Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1002 Frederick Road 21228 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Mechanic <u>Automotive</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1002 Frederick Road; Catonsville, MD 21228
lace of Disposition (Name of Date 20c. Location - City or Town, State Lou Weinkam, Jr. Personal Rep 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any Injury or ot
once. 1 ☑ Burial 2 ☐ mation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 9/6/2007 Druid Ridge Pikesville, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Sen 1630 Edmondson Avenue; Catonsville, MD Approximate Interval Between Onset and Death ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ire. List only one cause on each line. Part1. Enter the / seas shock or heart / ilure. Immediate Cause († nal disease or conditio resulting in death) DAYS SEPTIC SM OCK **Physician** /Medical Due to (or as a consequence of) Examiner CLOSTRIDIUM DIFFICLE COLITIS DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Day to (or as a sunsequence of) Examine PNEUMONIA DAYS. HEALTH CARE ACQUIRED that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68766. Physician/Medical YEARS HYPERTENSION COROWARY ARTERY DISEASE physi the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 s page 1∐ Yes 2 No certificate Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient 2 this 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: the Hospital or Attending 1 🖾 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 120347 M.D AUGUST 29 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAHUL JAIN 900 CATON BALTIMORE MD 21229 AVENUE 31. Date filed (Month, Day 2. Registrar's Signature State Registrar

AMLOR, RICHARD

Registrar

State

31. Date filed (Month Par

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) August 28, 2007 **Physician** David Bryan Thompson /Medical 4a. Facility Name (If not institution, give street and number) Marley Neck Health and Rehabilitation

7. Age (In yrs. last birthday)

Months Days Hours Min.

White Section Section 1 and Section 1 and Section 1 and Section 1 and Section 2 and Section 2 and Section 2 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Section 3 and Secti 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 9. Birthplace (State or Foreign 1954 Year **Funeral** Maryland 214**-**64-7473 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 461 Woodhill Drive 21061 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 White Specify: ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Fabric 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Richard Thompson Shirley Lynch မ 19a Informant's Name/Relationship (Type. Print, Cynthia Street/Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 418 Seagull Drive, Lewes, DE 19958 20b. Place of Disposition (Name of Meachowridge of Meachowridge) 20a Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. 4 □Donation 5 □ Other (Specify) Park 8-31-2007 | Elkridge, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. Signature of Furieral Service Deposes 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. to not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, cauling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: or Attending Physician: The law requires that the death certificate be ex ex ed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Medical Certification: Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the I 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check or one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) nd title of certifier 0 d ess of person who completed cause of death (Item 23a) (Type, Print) Annapolis MD

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month August 9:12 PM 24 Beulah C. Upman 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Agnes Hospital **Baltimore City** SŁ. Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Country) Tennessee 74 415-46-3366 March 26, 1933 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 □Yes 2XNo Catonsville Director **Baltimore** Maryland 10g. Citizen of What Country? U.S.A 10e. Street and Number 10f. Zip Code 21228 1935 Old Frederick Rd. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian, 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sewing Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Henard **Emory Ringley** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1935 Old Frederick Rd. Catonsville, Maryland 21228 Husband Mr. Alfred Upman, Sr. permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08/28/07 Marriottsville, Maryland Crest Lawn Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Strvice Licensee 1401293 22. Name and Address of Facility 3871 Old Columbia Pike Elicat City, MD 21043 de of dying, such as cardiac or espitatory arrest, 23a. Part1. Enter the dide se, or complications that cause d the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypoxia Physician /Medical Due to (or as a consequence of): Examiner Asphyxiation

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 📉 No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Tracheostomy Dependent Northral Vascular Accident Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed' Vital 1∐ Yes 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Division Subject disloged tracheostomy tube 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No August 24, 2007 Found 8:15 PM after death 2XI Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ō Irvington FutureCare 22 South Apple Avenue, Boltimore 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier august 25, 2007 D0053312

pman

o.

State Registrar

31. Date filed (Month, Day, Year) SEP 0 4 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michelle Henggeler, 900 caton MO 32. Registrar's Signature

Avenue, Baltimore, MD

	1 - State Registrar		0		Cer	tificat	e of E	Death		Date of Dea		2007		156 of Death
ian		ne (First, Middle, Las	st)							Month	Day	,2007		5 P M
ical		a Wenger  If not institution, give	e street and number)			4b. City,	Town, or l	Location of Dea		рсешь		County of Dea		
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To B	Nikand	r Sokoloh	orskv					Ju1	ia E	Rosand	owa			
-		Name/Relationship (		-	19b. Mailin	g Address	s (Street a	nd Number or F	Rural R	oute Numbe	er, City or	Town, State,	Zip Code)	
	Paul W	alter Wen	ger (Son)		11836	6 Gor	ntrum	Road,	King	gsvill	le, M	id. 210	87	
	20a. Method of Dis	sposition		20b. Pl	lace of Disposemetery, cren Micha	sition (Na	me of other place	Θ),	Date		20c. Loc	cation - City o	r Town, State	
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State Registrar 2300 DULANEY VALLEY RD.

Registrar's Signature

TIMONIUM, MD 21093

		1	For State Registrar	State of M	Marylan		artment rtificate					Reg. No.	007	281	57
Н	Physicia		1. Decedent's Name (First, Middle,	Last)							Date of Dea Month	Day	Year	3. Time of	Death
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	Examin	er	la. Facility Name (If not institution,				4b. City, To	ntor		Death			nce Geo		
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h	Funeral Director		578-42-7865	1 <b>∑</b> M 2□F	75	Yrs.	Months	Days	Hours		ne 2,			yland	
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ☒ Divorced	12. Was Decede Armed Force d 1 X Yes 2 If Yes, Give Year or Date	is? ⊒ No		Was Decede If Yes, speci 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Specify , Puerto Rica	Yes or No an, etc.)		4. Race - Ame Black, Whit Specify: wh	e, etc.	
21215-0036	thin 72 hou e. an "natura Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education grade completed)		16a. Dece (Give life.	dent's Usual kind of work DO NOT use	k done d e retired)	ntion Juring most )	of working		16b. Kir	nd of Business	/Industry	unk
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Ž	should Me Me mark	٩	19a. Informant's Name/Relationsh			19b. Maili	ing Address	(Street a	and Numbe	er or Rural R	oute Numb	er, City or	Town, State,	Zip Code)	
	alth ar 27 is er trau		Eric C. Waldow	/son		1409	Leice	ster	Dri	ve LaP	lata,	MD	20646		
Baltimore,	Pages 1 annent of Herant: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (Sp			Place of Disp cemetery, cre	osition (Nam ematory or ot	e of ther place	e)	Date		20c. Lo	cation - City or	Town, State	
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6876	<u>e</u> × e	dical		d											
Box	The law requires that the death certificat the has been signed by the attending phy page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Fetantat time of o	al death 3	□Ectopic pro					2	23d. Date of de Month		Year
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hysician/ . Examiner	1	1 1 1 0 - 1	Williams		Auç	oth Day gust 29, 200	County of Death	
	4a	Facility Name (if not institution, give street and	number)	4b. City, Town, or Loca	ation of Death	40	c. County of Deat	
		University of Maryland		Baltimore			and a Di	thalaga (State or Foreign
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uncia	3		21	Yrs. Months Days	Hours Min.	1/7/10	185	PA
Director	Ш	72-66-3780 12M 2				1-1-		00.11.00
		ual Residence of Decedent a. State 10b. County	10c. City, Town or Lo	ocation		12		10d. Inside City Limits
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2 823 E	11	Marital Status 12, Was	Decedent Ever in U.S. 13.	. Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin / (Specify Mexican, Puerto Ricar	n, etc.)	White, etc.	
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rmit. Pages I a	1	1 Burial 2 Cremation 3 Remo	val irolli State	or other place)	1 98	1501	Baltin	nove, md
permit. Pages 1 and 2 should'be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Be Completed by		Donation 5 Other Specify:	MH.	22 Name and Address (	of Facility and	troney	MISYCS	nove, md
Departn Import injury	1	1. Signature of Funeral Service Licensee		Vaugnac.	over Math	Dilde	201timare	
E D E E		23a. Parti. Enter the disease, or complications	the death Do not e	551 Bartim	such as cardiac or re-	spiratory arrest,	shock, or heart	Approximate Interval Between Onset and
ysician	7	failling List only one cause on each line.		, mor and more and you				Death
Medical	١	Immediate Cause (Final disease a. Gunshe	ot wound of torso					
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Fig. A. The fig. A.	tior	5 Feliding				oof Leastion (S	treet and Number	or Rural Route Number, C
Arte	ica		8e. Place of Injury - At home, fa	ırm, street, factory, office		as Tours Ct	ata)	
DIVISION tal or Attendiums after death.	Certification:	determined /	Specify) Local Street				Road, Brooklyn	
To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.		29a. Certifier 1 Certifying Physician: To	the best of my knowledge, dea	ath occurred at the time, o	date and place, and	due to the cause	e(s) and manner a	s stated. e to the cause(s)
he H in 24 he Fr	Medical	29a. Certifier 1 Certifying Physician: To Check only one) 2  Medical Examiner: On the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of	e basis of examination and/or in	Investigation, in my spins		, ure ume, date a		
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	2	25b. Signature and tide of continue	$\Delta$ .	0.0	C.M.E.		August 29, 2	2007
		(alagel)	12				L	
		30. Name and address of person who comple	ted cause of death (Item 23a)		Wasana MD 21	201		
7	i		Madical Evaminar 1	11 Penn Street. Ba	altimore, MD 21.			
7		Zabiullah Ali, M.D. Assistant	Medical Examiner 1	11 Penn Street, Ba	altimore, MD 21		OCME	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Whitford Day Year **Physician** 13:300M Donald 31 2007 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital Baltimore City 8. Date of Birth (Month, Day, Year) if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** New York Days Hours Min 1 X M 2 □ F 64 Director 051-34-6513 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "naturai", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Marvland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1001 Coleridge Ct. Apt. 21229 U.S.A. r death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★ Tayles 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify δ. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineer Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be intent of Health and Mental int: If item 27 is marked o Charles Whitford Ann Lupa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 994 Joshua Tree Ct. Allisyn Pletch - daughter Owings Mills, 21117 Mđ. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Sept. 1,2007 Baltimore, Md. 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licensee . Harth Eldoneld 11605 Reisterstown Rd. Owings Mills, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Pheumonia disease or condition resulting in death) month /Medical Due to (or as a consequence of): Examiner Multiple Myeloma months Sequentially list conditions, if any, leading to finine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to (or as a supsequence of): Examiner sician and burial-transit the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ned by the a ☐Yes 2☐No 9 Unknown 9 TUnknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA 2 To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft 29a. Certifier 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier , Medical Doctor August 31, 2007 Res-000 VILLICA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miya Paterniti, The Johns Hopkins Hospital, 400 Morth Wolfe Street, Baltimore Manjiand 21287 32. Registrar's Signature 1 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ц			For State Registrar	State of Maryland	Depa	artment of F	lealth a Death	ınd M		iene 200	7 28	160
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Las.     William C     Aa. Facility Name (If not institution, give)	Wanzor street and number)		4b. City, Town, o			2. Date of Deat Month 08	2 ^{Day} 200	20:	of Death 43 M
* 20 20	Funeral Director		5/8-04-113/		birthday) Yrs.	Takoma If Under 1 Year Months Days			ry I and  8. Date of Birth (Month, Day, 04/03/1	9.	Jomery Birthplace (Stai Country) Shingto	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  DC  10e. Street and Number  1349 Spring Road  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grade)  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last)  Cecil Campbell  19a. Informant's Name/Relationship (7 Ruth Cabbagestal)  20a. Method of Disposition  1 Burial 2 Cremation 3 Characteristics of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control	N W  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:  June 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section 1. Section	13. 13. 13. 166a. Decee (Give lifte.) Copy 19b. Maillin 13 e of Disposetery, cre.		dispanic Origan, Mexican Specify: Dation during most di Cian 18. Mothe Road Road Ce) Sess of Facilities	er's Name Rut Rut IN W	city Yes or No-Rican, etc.)  (First, Middle, I h Wanzo Washin wate /2007	Black, Specify:  16b. Kind of Busin  Self-Emp Maiden Surname)  r; City or Town, Ste gton, D ( 20c. Location - Cit Triangle  Oyster Fu	ate, Zip Code) C 20010 Ty or Town, State  Wirgin	nia Home
68760,	hitrate be executed with the purish and but sician and is the burial-transit	edical Examiner	23a. Part1. Enter the disease, or composhock, or heart failure. List only disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequer  b. Limitu (or as a consequer  c. Due to (or as a consequer  d	Place of):	neumo	la.	S	r respiratory arr	est,	Approxisi Interval Onset a	Between nd Death
.O. Box	ures that the death certifica signed by the attending ph d be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnanc 1□Live birth 2□Fetal d 4□Pregnant at time of dea 9□Unknown	eath 3[	⊒Ectopic pregnand ⊒ Other (specify)	y -			23d. Date of Month	-	Year
Δ.	v requ	Completed by Ph	Part II. Other significant conditions of	ontributing to death but not resulti	ng in the ι	inderlying cause gl	ven in Part I		1 ☐ Y  24a. Was a autop	n 24b. We price med?	Probably 4 ere autopsy finding to completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at the completion at	Unknown
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Division or Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has been proposed by the funeral director, page 2	Certification: To	27. Manner	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	of 28c. Inju Wo M 1	ıry at ork? ]Yes 2□	No	28d. Describe h	ow injury occurred		Number,
\	e Hospita 24 hours e Funera letely fille	Medical C	29a. Certifier 1 ☐ CertifyIng Ph (Check only 2 ☐ Medical Exar	ysician: To the best of my knowledge: On the basis of examination and manner stated.	edge, dea n and/or i	th occurred at the the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervised in the supervi	ime, date a opinion, de	nd place, ath occur	and due to the ored at the time,	cause(s) and manr date and place, an	ner as stated. Id due to the cau	ıse(s)
	To th To th	Me	29b. Signature and title of certifier	MD		29c. Licen	se number	601	Sprf	29d. Date signed (	28-7	
X	$C^{1}$		30. Name and address of person who	completed cause of death (Item-2	3a) (Type	, Print) 5	ilva	4	Sprif	· M	0 209	103
	Sta Regist		31. Date filed (Month, Pay Year) 4	2007 32. Registrar's Signatu	re,	Garle						

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** W. WILLIAMS August, 23, 2001 1.52 An /Medical 4a. Facility Name (If not institution, give street and number)
Heartland Health Care Center
of Hyattsville

5. Social Security Number
6. Sex
7. Age ( 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Hyattsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months XXM 2 F 220-05-9379 Feb 24, 1920 Director New York Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No District Heights MD Director Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1913 Tanow Place U.S.A. 20747 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give 2/22/44 Year or Dates 4/2/46 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 🛣 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Truck Driver permit. Pages 1 and 2 should be filed:
Department of Health and Mental Hygii
Important: If item 27 is marked other
any Injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Winston Williams Carrie Chew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1913 Tanow Place 19a. Informant's Name/Relationship (Type. Print) Mary Crawford Williams/Wife District Heights, MD 20747

20b. Place of Disposition (Name of Cemetery, grematory or other place)

201. Place of Disposition (Name of Cemetery, grematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other pla Maryland Veterans 8/28/2007 1 Burial 2 Cremation, 3 Femoval from State Cheltenham, MD 4 ☐ Donation 5 Dother (Specify Cemetery Name and Address of Facility Benry S. washington & Sons Co., Inc., 4925 N.H. Burroughs Avenue, N.E. Washington, DC 20019 21. Signature of Fu eral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) YOCA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit and Due to (or as a consequence of) physician Physician/Medical as the l attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an page 2 certificate 1□ Yes 2 X No e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifica letely filled in by the funeral director. p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 ☐ ER/Outpatient P 1 ☐ Yes 2 🔀 No 1 Inpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 Accident 3 Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

be execute Records, P.O. or Vital within 2 To the

Maryland 21215-0036

Baltimore,

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

30. Name and address of

31. Date filed (Month, Day,

who completed cause of death (Item 23a) (Type, Print)

29c. License number

PARKWAY GREETEBELT MAR

_			For State Registrar	State of Maryla	•	artment of H rtificate of L		, ,	iene _{eg. No.} 2007	28162
*	Physici		Decedent's Name (First, Middle,		arie	Watson		2. Date of Deat Month August	Day Year 28, 2007	3. Time of Death $12 : 45 P^{M}$
	/Medio		4a. Facility Name (If not institution,			4b. City, Town, or			4c. County of Deat	th
		-	7345 Hughes Av  5. Social Security Number 6		rs. last birthday)	Edgem If Under 1 Year	ere If Under 24 Hrs.	8. Date of Birth	Baltimo	
	Funeral Director		234-38-8648	1□M 2XF 82	Yrs.	Months Days	Hours Min.	(Month, Day, July 24	,1925 Wes	hplace (State or Foreign buntry) t Virginia
	pu »		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo	cation				10d. Inside City Limits
	Maryla f shov led at	or		altimore	ony, rount of Le	odion	Edgemen			1 ☐ Yes 2X No
	n the l	irec	10e. Street and Number	arcimore		10f. Zip Code	Edg eller		0g. Citizen of What Co	untry?
	filed within 72 hours after death with the Maryland Hygione. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	7345 Hughes Av			2121			United Sta	
	items items ner m	nne	11. Marital Status 1 □ Never Married XX Married	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2\( \frac{2}{2}\( \frac{1}{2}\) No	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
036	urs aff al", or Exami	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes <b>200</b> No	Specify:		Specify:	White
5-0	72 ho 'natur dical I	eted	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	ing I	16b. Kind of Business/	Industry
121	within ene. than '	Completed	Elementary/Secondary (0-12) 12 Years	College (1-4or 5+)		<i>DO NOT use retired</i> sperson	) -		Retail	
1d 2	e filed Il Hygi other ent, tl	BeC	17. Father's Name (First, Middle, La	ast)			18. Mother's Name	e (First, Middle, M		
ylar	ould be Menta arked atic ev	ToB	Lloyd Brooke				Grace S	Smeltzer		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship Mr. Daniel G. W			ng Address <i>(Street a</i> 5 Hughes			, City or Town, State, 2 Maryland	Zip Code) 21219
ore,	of He of He of item		20a. Method of Disposition 1   Burial 2 □ Cremation 3	DRemoval from State	o. Place of Dispo cemetery, cre	sition (Name of matory or other plac	e) !	Date	20c. Location - City or	Town, State
<u>Ē</u>	t. Pag tment <b>tant:</b> I		4 □ Donation 5 □ Other (Spe	cify) G	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	of Faith		./2007	Baltimore	e, Maryland
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103	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
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Вох	death certifica attending phi d for use as th	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ F		∃Ectopic pregnancy			23d. Date of de	,
	The law requires that the death certificate to has been signed by the attending physioage 2 should be detached for use as the	Physician/Med	in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	4☐Pregnant at time of		Other (specify)			Month	Day Year
P.0	w requires that the de been signed by the should be detached		Part II. Other significant condition	s contributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
rds	quires n sign ald be	d by						1 □ Ye	es 2 No 3 Pi	robably 4 □Unknown
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Vita	Physician: The la this certificate had ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:	_	Othe	26. Place of Deat			
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ion	ath. rr: Afte	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	) Injury		<br Yes 2 □ No			
Division or Vital Records,	or Atte	Certification:	3 Suicide 6 Could no 4 Homicide determin		t home, farm, sti ec <i>ify)</i>	reet, factory, office		28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,		(Check only 2 Medical E	Physician: To the best of my kaminer: On the basis of exam	knowledge, deat ination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) and manner as late and place, and due	s stated. e to the cause(s)
	omple	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. License	e number	2	9d. Date signed (Mont	th, Day, Year)
	->-0		1 Chim	Parshall		D40	0008		8/29/	0.7
	4		30. Name and address of person w	no completed cause of death (I	tem 23a) (Type,	Print) ANKLIN		105 0	0 0 .	THORE, M
	Sta	ate.	31. Date filed (Month, Day, Year)	AALL 32 Registrar's Si	nature	するドドラ	2 2 601	ake D	DAL	incore, m
	318	T.C	CED 0 4		20 19	0 0				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Helen Louise Howerton Whitmore 133 YUGUST 30 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1) Feb. 25, 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🕅 F 1930 Virginia **Director** 224-34-1875 77 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show "natural", or items 23a or 28a-f sh edical Examiner must be notified 1 ☐ Yes 2 🔯 No Director Baltimore Catonsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21228 5423 Jacks Court Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🖾 No 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: White þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the Bank Trust Officer d 2 should be filed w th and Mental Hygiei 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Cornett E. Preston Howerton Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) nt of Health a Vicki Whitmore Allen / Daughter 5423 Jacks Court, Catonsville, Maryland 21228 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or other 3 ☐Removal from State 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) Southlawn Memorial Park Prince George, Virginia 2007 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. M00896 7557 Wisconsin Ave., Bethesda, MD 20814-3501 23a. Part1. Enter the diseace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each fine. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a cons-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed and burial-tra Due to (or as a consequence of) Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 DNo Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 1□ Yes Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 🗌 Yes 1 Inpatient ER/Outpatient 3 □ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of ea 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check or and manner stated the 29b. Signą 29c. License numbe 29d. Date signed (Month, Day, Year) ٥

HO

State Registrar filed (Month, Day,

DHMH 17 Rev 1/2001

00 Catun

nd address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

ian	1. Decedent's Name (First, Middle, La.	st)	Wells		2. Date of Death Month	Day Year 200	3. Time of Death 951 M						
cal ner	4a. Facility Name (If not institution, give The Johns Hock) 5. Social Security Numberunk 6. S	Hospital	4b. City, Tow Ball ast birthday) If Under 1 Yo	ear If Under 24 Hrs	th  S. Vate of Birth  (Month, Day, Yo	4c. County of Deat							
	Usual Residence of Decedent  10a. State 10b. County	05	, Town or Location		Aug 27, 1	.921	10d. Inside City Limits						
ctor	MD	1	Baltimore				1∰Yes 2□No						
Funeral Director	10e. Street and Number 1603 Darley Avenu	1e	10f. Zip Coo	de 21213	10g	. Citizen of What Co USA	untry?						
ınera	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13. Was Decedent	of Hispanic Origin? (S Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White							
ò	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 Z️YNo If Yes, Give Year or Dates:	1 ☐ Yes 2 <b>∑</b>	No Specify:		Specify: b	lack						
Completed	15. Decedent's Ed (Specify only highest gra-	de completed)  College (1-4or 5+)	16a. Decedent's Usual Od (Give kind of work do life. DO NOT use re	one during most of wo	Industry u								
Re	unk 17. Father's Name (First, Middle, Last,	<u>ink</u>	un	k 18. Mother's Na	me (First, Middle, Mai	iden Surname)	un						
0	19a. Informant's Name/Relationship (		19b. Mailing Address (Str			0.1.00	Zip Code)						
	Johns Hopkins Hos  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 □ Donation 5 図 Other (Specif	20b. Pl   Removal from State	600 Wolfe Sace of Disposition (Name of metery, crematory or other	f		21287 c. Location - City or	Town, State						
	21. Signature of Enneral Service Licensee Ronald S. Wade Director State Anatomy Board 655 W. Baltimore Street  Baltimore, MD 21201												
	23a. Part1. Enter the disease, or com shock, in heart failure. List only Immediate Cause (Final disease or condition	plications that caused the death one cause on each line.	. Do not enter the mode of	dying, such as cardia	ac or respiratory arrest	,	Approximate Interval Between Onset and Death						
lical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to intrindicate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):												
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23d. Date of del Month	ivery Day Year										
þ	Part II. Other significant conditions of	contributing to death but not resu	Iting in the underlying cause	e given in Part I.	23e. Did tobac	co use contribute to	the cause of death?						
Completed		24a. Was an autopsy performe 1∐ Yes 2 [a	prior to	utopsy findings availabl completion of cause of 2  No									
To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ➡ No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3 □ DOA	Other:	eath (Check only one) Home 5  Residence	e 6 ∏Other (Spe	cify)						
Certification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury 28c.	28d. Describe how		5.177							
rtifica	2 Accident investigation 3 Suicide 4 Homicide   M   1 Yes 2 No    28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or F City or Town, State)												
(a)													
Medical Ce		completed cause of death (Item The Johns Hopki 32. Registrar's Signat	29c. Lic	cense number	29d	Date signed (Mont	h, Day, Year)						

25, 26, 27, 29cDivision or Vital Records, P.O. Box 68766, Properties and 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** James R. Wright 8/30/2007 6:49pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1903 Ridgewick Rd Glen Burnie Anne Arundel 7. Age (In yrs. last birthday)

56 Yrs. 8. Date of Birth (Month, Day, Year) 4/30/1951 If Under 1 Year | If Under 24 Hrs. 5. Social Security Numb 217-52-6687 Birthplace (State or Foreign Country) **Funeral** Hours Days XXM 2□ F **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at MD Anne Arunde 1 ☐ Yes 2 ☐No Glen Burnie Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 3 1903 Ridgewick Road 21061 USA Funeral death r than "natural", or items the Medical Examiner me 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 9 3 ☐ Widowed 4 M Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Master Electrician Construction Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event, to once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ith and Mental h Be John W. Wright, Sr. Donna J. Cramer ပ္ 19a. Informant's Name/Relationship (Type. Print)
Pauline E. Iman / Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Cloverhill Road, Pasadena MD 21122 saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 09/04/2007 Baltimore Maryland 4 □ Donation 5 □ Other (Specify) 4 Donation 5 Other (Specify)

21. Signature of Funeral Service Licensee Victor P. Doda, Tr. Name and Address of Facility

Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardi **Physician** /Medical Due to (or s) consequence of): Examiner Sequentially list conditions, if any action of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown þ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed cate has been a page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division or Vital Records,

To the Hospitar — within 24 hours after death.

To the Funeral Director: After the Funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of

10

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only

30. Name and address of pelson who completed cause of death (Item 23a) (Type, Print)
DEBAJIT Roy 7845 OAWOOD 32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0060103

29d. Date signed (Month, Day, Year)

8-31-2007

ROAD, GLEN BURNIE, MD 21061

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **25** Month Year **Physician** THOMAS ROBERT YOST <del>-26-</del> 2007 AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner FUTURECARE CANTON BALTIMORE n/a 8. Date of Birth (Month, Day, Year) 09/10/1945 If Under 24 Hrs. Hours Min. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days 9. Birthplace (State or Foreign 1**∑** M 2□ F 62 215 46 5928 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD BALTIMORE ROSEDALE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7912 BRIDGE AVENUE 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: WHITE Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) MD TRANS. AUTH. POLICE OFFICER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DANIEL RAYMOND YOST MARTHA UNK. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLAIRE YOST / WIFE 7912 BRIDGE AVE BALTIMORE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 31, August 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bayview Crematory BALTIMORE, MD 4 Donation 5 Dother (Specify) 2007 21. Signature of Funeral Service Licensee connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. P. irt1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Hypertensive Arteriosclerotic Coronary Vascular Disease years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Pulmonary Embolus (August 2007) 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Episodes of aspiration pneumonia autopsy performed? Docubitus ulcors
25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

requires that the death certificate be executed Box 68760, P.O. Division or Vital Records, ospital or Attending hours after death.

**Funeral** 

Director

Show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Monee.

Physician

/Medical

Examiner

attending physician and for use as the burial-tran

signed by the a

cate has l certificate

After this

29b. Signature and title of certifier

Milwell

Kewatrie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

72 hours after

Baltimore, Maryland 21215-0036

within 24 hours after com.

To the Funeral Director: Aft

To the Funeral Director: Aft

32. Registrar's Signature 7310 Ritchie Highway #508 Glen Burnie, Maryland Michael Schwartz, M.D. 31. Date filed (Month, Day, Year) State SEP 04 Registrar

29c. License number

D1966

29d. Date signed (Month, Day, Year)

08-27-2607

DHMH 17 Rev 1/2001

	1- State of Maryland / D	Department of Health and M Certificate of Death	lental Hygien 2007	28168					
Physician	1. Decedent's Name (First, Middle, Last) Martin A1	terman	2. Date of Death Month August 13, 2007	3. Time of Death 5:37 A M					
/Medical Examiner	4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center	4b. City, Town, or Location of Death Cheverly	4c. County of Deal Prince Ge						
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birt 212–92–8698 1 □ M 2 □ F 44 V	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day Year) November 8,1962 Unk	hplace (State or Foreign untry) NOWN					
p >	Usual Residence of Decedent  10a. State			10d. Inside City Limits 1 □Yes ♣□ No					
offer death with the Mar r tieme 23e or 28e-1 el niner must be notified Funeral Director	10e. Street and Number 3001 Plaza Drive	101. Zip Code 20746	10g, Citizen of What Co USA	untry?					
s 1 and 2 should be filed within 72 hours effer death with the Maryland frequency and Mental Hygiene. It has the and Mental Hygiene. Other traumatic event, the Madical Examiner must be notified at the Traumatic event, the Madical Examiner must be notified at the Traumatic event.	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sprill Yes, specify Cuban, Mexican, Puerto							
ed within 72 houygiene.		Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired) sabled	ng Not Applica						
build be filed v Mental Hygie arked other aric event, th	17. Father's Name (First, Middle, Last)  Alterm	18. Mother's Name	e (First, Middle, Maiden Sumame) VN						
nd 2 shou aith and M 27 is mar r traumat	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or Aura 00 Parston Dr., Fore		Zip Code)					
permit. Pages 1 and 2 Department of Health a importent: if itsm 27 is eny injury or other trau		y, crematory or other place)	20c. Location - City or Edgewater,						
permit. Departri imports eny inju	21. Signature A Puneral Service)Licenses	22. Name and Address of Facility Geo 6160 Oxon Hill Rd.,							
Physician	23a. Part 1. Enter the disease, or complications that caused the death. Do n shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Atherosclerotic	not enter the mode of dying, such as cardiac of Cardiovascular Disea		Approximate Interval Between Onset and Death					
/Medical Examiner	resulting in death)  Due to (or as a consequence of Respiratory Fai	of):							
icate be executed physician and the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ol):  Due to (or as a consequence ol):  Due to (or as a consequence ol):								
To the Hospital or Attending Physician: The law requires that the death certificatine 24 hoursels better death.  Within 24 hoursels Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Medical Certification:		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of de Month	ivery Day Year					
uires that the signed by Id be detacted by Aby Ph	Part II. Other significant conditions continuing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to 1 ☐ Yes 2 ♣ No 3 ☐ Po	o the cause of death?					
The law required to the law required base a should completed	-		autopsy prior to performed? death?	utopsy lindings available completion of cause of					
certifica rector, p	25. Was case referred to medical examiner?	0	(Check only one)						
Attending Physician: The law death. ector: Alter this certificate has by the funeral director, page 2	T Impatient 24-Pervou	tpatient 3 DOA 4 Nursing No	me 5 ☐ Residence 6 ☐ Other (Spe 28d. Describe how injury occurred	city)					
tai or Attending Programmers efter death.  e) Director: After ted in by the funerance certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, la building, etc. (Specify)	rm, street, lactory, office	28f. Location (Street and Number or R City or Town, State)	ural Route Number,					
To the Hospital or within 24 hours efft To the Funeral Discompletely filled in Medical Cert		e, death occurred at the time, date and place, d/or investigation, in my opinion, death occurr	and due to the cause(s) and manner a ed at the time, date and place, and du	s stated. to the cause(s)					
To th To th compl	29b. Signature and title of certifier  MD	29c. License number # 000601	29d. Date signed (Moni						
BY	30. Name and address of person who completed cause of death (Item 23a) (Tahmina K. Ahmed, M.D. 831 Univers		pring. MD 20903						
State Registrar	31. All (Born outh 200 year) Lessen 32. Registrar's Signature		F6, 2000						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** SCOTT DAVID BANNON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** County Hospital Washington Washington Hagerstown 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 220-52-1883 Director AUG. 10,1959 48 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 Applecreek 21702 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No White Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Landscaper 12 Landscaping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald. Bannon Norma Humphries ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8879 Inidan Springs Rd. / Frederick , MD Donald F. Bannon / Father 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 08/21/2007 | Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 1621 Opossumtown Pike/ Frederick, MD 21702 Immediate Cause (Final disease or condition resulting in death) Stag **Physician** tma 6 /Medical Due to (or as a consequence of Examiner rati Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy perform 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No 1 npatient 2 ER/Outpatient 3 DOA မ 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending (Month, Day Year) 1 Natural Injury 5 ☐ Pending within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 052323 30. Name and address of person who completed cause of death (Item 23a) (Type, Pring 26 Waseem 31. Date filed (Month, Day, Year) State AUG 2 1 2007

Registrar

	1 - State Registrar Ameno#19a.Pe					2. Date of Deatl		3. Time of Death		
an al	Marsha Ab	bott	Bray			August	Day Year <b>13, 2007</b>	16:48P		
er	4a. Facility Name (If not institution, g			4b. City, Town, o	r Location of Death		4c. County of Deat			
	Holy Cross Hosp				Spring		Montgome			
		. Sex 7. Age 1	(In yrs. last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Co	hplace (State or Fore		
	266-74-8181 Usual Residence of Decedent		62 Yrs.			August 2	23,1944 F	lorida		
	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limi		
ctor	MD Prince	Georges	Greenbe	elt				1 □ Yes 2 □ 1		
Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?		
<u>ra</u>	2T Laurel Hill			20070			United St			
ś	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces?		<ol> <li>Was Decedent of F If Yes, specify Cub</li> </ol>	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit			
2	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	· _	1 ☐ Yes 2 ☐ No	Specify:		Specify:	**		
	15. Decedent's	Education	16a. Dec	cedent's Usual Occup	pation	. 1	6b. Kind of Business/			
5	(Specify only highest g	College (1-4or 5+	life	ve kind of work done  . DO NOT use retire	during most of work d)	ing				
combiered	12	4	Te	chnical E			Governmen	t		
2	17. Father's Name (First, Middle, Las				18. Mother's Name	,	laiden Surname)			
2	William John	Abbott	100.00		Myrtle	Posey				
	19a, Informant's Name/Relationship Abigail Bray	/Daughter					City or Town, State, 2			
	20a. Method of Disposition	/ Daughter	20b. Place of Dis	Southern position (Name of			on, DC 200 Oc. Location - City or			
	1 ☐ Burial 2 ☐ Cremation 3	Removal from State	cemetery, c	rematory or other pla	ce)		-			
	4 ☐ Donation 5 ☐ Other (Special Service Light)			rth Garden	S 8/21,	/2007 L	ake Worth,	Florida		
	12.0					/ HomeF	482 Lee alls Chu	Hwy 2204 rch Va		
	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused t	he death. Do not e					Approximate Interval Between		
	Immediate Cause (Final disease or condition	SEPTIC S						Onset and Death		
	resulting in death)	a	consequence of):							
	Sequentially list conditions,  NECROTIZING PANCREATITIS									
Examine	that initiated events resulting in death) Last  C.  Due to (or as a consequence of):									
2										
5		d								
Ü	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pr					23d. Date of del	ivery		
I / INIC	in the past 12 months? 1 ☐ Yes 2 😿 No	4☐Pregnant at ti		23b. Was decedent pregnant in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)						
Old I HIGH	9 ☐ Unknown 9 ☐ Unknown									
II y SICIALIVING										
		contributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?		
2		contributing to death but	not resulting in the	underlying cause giv	en in Part I.		s 2 No 3 Pr	_		
2		s contributing to death but	not resulting in the	underlying cause giv	en in Part I.	1 ☐ Ye	s 2 No 3 Pr	obably 4 Unkno		
2		s contributing to death but	not resulting in the	underlying cause giv	en in Part I.	1  Yes	s 2 No 3 Pr	obably 4 Unkno		
(	Part II. Other significant conditions  25. Was case referred to medical examiner?		not resulting in the	, 0	26. Place of Death	1  Yes  24a. Was an autopsy perform 1  Yes 2	24b. Were au prior to death?	obably 4 Unkno		
ام حم مسالمات م	Part II. Other significant conditions  25. Was case referred to medical examiner?  1 □ Yes 2 ☑ No	Hospital: 1 🙀 Inpatient	t 2□ER/Outpati	ent 3□ DOA Oth	26. Place of Death er: 4 □ Nursing Ho	1  Ye:  24a. Was an autopsy perform 1  Yes 2 n (Check only one	24b. Were au prior to death?  Red? death?  No 1   Yes  Compared to the death?	obably 4 Unknow topsy findings availa completion of cause of X No		
ام حم مسالمات م	Part II. Other significant conditions  25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 □ Pending	Hospital: 1 <del>∑</del> Inpatient 28a. Date of Injury (Month, Day	t 2 □ ER/Outpati	ent 3□ DOA Oth	26. Place of Deather: 4 □ Nursing Ho k?	1   Yes 2   (Check only one	24b. Were au prior to death?  Red? death?  No 1   Yes  Compared to the death?	obably 4 Unkno stopsy findings availa completion of cause of		
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fa population of or minimum or	Part II. Other significant conditions  25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigating investigating determines  4 Homicide Could not determine	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day) on be d 28e. Place of Injury building, etc.	t 2 ER/Outpati	ent 3 DOA Oth of 28c. Injur Wor M 1 Street, factory, office	26. Place of Death er: 4 □ Nursing Ho y at k? Yes 2 □ No	1   Yes  24a. Was an autopsysperform 1   Yes 2  1 (Check only one  me 5   Resider 28d. Describe how  28f. Location (Str. City or Town,	24b. Were au prior to (death? No 1   Yes No 1   Yes No 2   Other (Spew winjury occurred	topsy findings availal completion of cause of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s		
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Integrical Certification: 10 be Completed by Physician/Integ	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigate 2 Accident 3 Suicide 6 Could not determine.	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day) on be 28e. Place of Injury building, etc.  Physician: To the best of aminer: On the basis of e	t 2 ER/Outpati	ent 3 DOA Oth of 28c. Injur Wor M 1 street, factory, office ath occurred at the tii investigation, in my c	26. Place of Death er: 4 □ Nursing Ho y at k? Yes 2 □ No  me, date and place, ppinion, death occur	24a. Was an autopsy perform 1 Yes 2 The (Check only one me 5 Resider 28d. Describe how 28f. Location (Str. City or Town, and due to the cared at the time, da	24b. Were au prior to (death? No 1   Yes No 1   Yes No 2   Other (Spew winjury occurred	atopsy findings availated tompletion of cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the caus		

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) AUG 1 6 2007

■ Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

			For State Registrar	State of N	aryland		artment <i>rtificate</i>			nd Me		giene Reg. No		281	71
			1. Decedent's Name (First, Middle,	Last)						2	. Date of De Month	ath Day	v Year	3. Time of	Death
	Physici /Medic		LEE ELLA	BURIL						A	ugust	14,	2007	9:16	A ^M
	Examin		4a. Facility Name (If not institution, g Prince George's				4b. City, T Ch	own, or Lo		Death			County of Deat		s
	Funeral Director		5. Social Security Number 495–22–3817	.Sex 7. A 1 M 2 DXF	Nge (In yrs. Ias 94	t birthday) Yrs.	If Under 1 Months		If Under 2 Hours	Min.	Date of Bir (Month, Da		Co	hplace (State of untry) On TN	r Foreign
-	p.		Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Taum ar la	anting							10d. Inside Ci	ity Limits
	shov	5	,	George's			lboro							1 ☑ Yes	
	28a-f	rect	10e. Street and Number	GEOIGE 5	оррс	.1 1161	10f. Zip (					10g. Cit	izen of What Co	untry?	
	3a or	Ö	11311 Serrington	n Court			20	772				Unit	ted Stat	es	
(O	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any fourty or other traumatic evant. Its Medical Exattria is used to indiffed a once.	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Deceder Armed Forces	it Ever in U.S. No		Was Deceder f Yes, specif	ty Cuban,	panic Orig Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No can, etc.)	D-	14. Race - Ame Black, Whit	e, etc.	
2-0036	ours a	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates										Black	
<u>7</u>	"natu	ete	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual kind of work DO NOT use	done dur	on ring most	of working	1	16b. K	ind of Business	Industry	
2	withir Bne. than	Completed	Elementary/Secondary (0-12) 8 years	College (1-40	r 5+)		ndow D	,	ner			]	Private		
<u>8</u>	illed Hygi other	Be C	17. Father's Name (First, Middle, La	rst)				11			First, Middle		Sumame)		
<u>Ja</u>	Menta Menta arked artic ev	To E	George Jones								Mosle				
Maryland 2121	and and le man		19a. Informant's Name/Relationship										or Town, State, 2		
	1 and Health am 27		Virgenia L. Embre	ey-Brock/Da	20b. Plac	e of Dispo	sition (Name	e of		Dat			ocation - City or		
more,	ages ant of nt: If it y or o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		е		natory`or ott Cemete		!	10 2	3 200	7 (	St. Loui	is. MO	
alti	mit. F partmi portar y Injur		21. Signature of Funeral Service Li		TOGIV	> 22	2. Name and	Address					al Home		
<u>~</u>	Depa Impo any I		1 phoned 1	Kanok	1	4(	)01 Be	nnin	g Roa	ad, N	E Wasl	ningt	ton, DC		
	Physician		23a. Pant. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final	omplications that caus nty one cause on each	ed the death.	Do not ent	er the mode	of dying,	such as o	cardiac or i	respiratory a	irrest,	ene	Approximat Interval Bet Onset and	ween
	/Medical		disease or condition resulting in death)	a. Due to (or a	s a conseque	nce of)	- //	0	Mc		1)				
Н	Examiner	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	Onsequer	nce of):	- 0	10	10	7	<b>4</b>				
	nsit	nine	Cause (Disease or injury	0.00 10 (01	ma		1			2					
o T	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or a	is a consequer	nce of):		;							
8760	sate be shysicia the bur	Icai		d											
9	entifica ling ph e as tl	Med	IF FEMALE:	00a li van autoon	a of presented	.,							004 0-1		
.O. Box	The law requires that the death certifica ate has been signed by the attending prage 2 should be detached for use as the	Physician/Medical	23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 No 9 ☐ Unknown		2 Fetal de at time of deat	eath 3[	Ectopic pre Other (spe			-			23d. Date of de Month	-	Year
۵.	uires that t signed by d be deta	by	Part II. Dther significant condition	s contributing to death	but not resulti	ing in the u	nderlying ca	use given	in Part I.			tobacco	use contribute to	L	death? Unknown
Records,	law requas been as been so a shou	Completed									24a. Was		24b. Were at prior to death?	utopsy findings completion of c	available ause of
<u>~</u>	The										1 ☐ Yes	2 No		2 🗆 No	
=======================================	Physician: rthis certifica ral director, I	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	tient 2 EF	NOutpatier	nt 3 🗆 DO/	Other			Check only		6 ☐Other (Spe	cifv)	
Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tion; To	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Ir (Month, L		8b. Time o Injury		3c. injury a Work?		28	d. Describe			ony)	
)ivisi	I or Attendi after death. Diractor: A d in by the fu	Certification:	2 ☐ Accident Investiga 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be 28e. Place of	njury - At hometc. (Specify)	e, farm, sti	reet, factory,	office		28	f. Location ( City or To		nd Number or R e)	ural Route Nun	nber,
_	To the Hospital or Attending within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune.	edical Co	29a. Certifier (Check only one)  Certifying 2 Medical E.	Physician: To the be- kaminer: On the basis	of examination	edge, deat n and/or in	h occurred a vestigation,	it the time,	, date and nion, deat	d place, an	d due to the	cause(s , date an	) and manner a d place, and due	s stated. to the cause(s	s)
	To the within 2 To tha comple	Med	29b. Signature and title of certifier	and manner			29c.	License r	number			29d. Da	ite signed (Moni	h, Day, Year)	
)	2 12		1/	Varie	1			0	50	3/	8	8	1141	07	
			30. Name and address of person w	ho completed cause of	death (Item 2	3a) (Type,	Print)	DR	0	HEVE	Rhy	m	0 207	283	
	Sta Registi		AUG 1 6 2007	Taren 32. Regis	strar's gpatu	4									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year 6 32 A M IRMA J. BUSSIE , 2007 ugust. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Prince George's Lanham | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Dec. 22, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🛣 F 579-46-5530 71 South Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 √ Yes 2 No Lanham Maryland Prince George 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10308 Chautauqua Avenue 20706 USA 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Currency Examiner Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Leola 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10308 Chautauqua Ave., Lanham, MD 20706 of Disposition (Name of Date 20c. Location - City or Town, State Kim Bussie (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State National Harmony 4 Donation 5 Dother (Specify) 08/18/2007 Hyattsville, MD 22. Name and Address of Facility Jordan Funeral Service, Inc. 21. Signature of Funeral Service Licensee 4001 Benning Rd., N.E., Washington, DC 20019 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Severe Shock 24 Hours Due to (or as a consequence of): Metabolic Acidosis Sequentially list conditions, if any, leading to immediate cause. Emer underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Sepsis 10 Days Due to (or as a consequence of): Hepato Renal 72 Hours <u>Failure</u> 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Hepititis C. Hypoalbuminemia. HTN. New onset 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Diabetes, S/P Lumbar Laminectomy, Laparotomy, Intestinal 24a. Was an autopsy performed? 1□ Yes 2 No Spine and Abdomen Obstruction, Hernia repair, Wound infection 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical **Examiner** the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

**Examiner** 

Director

Funeral

þ

Completed

Be ပ

**Funeral** 

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryfand 21215-0036

Examiner Physician/Medical þ Completed Be မ

within 24 hours after death

To the Funeral Director:
completely filled in by the (8)

27. Manner of Death

Medical Certification: 29a. Certifier

KRISHNA MURTHY M.D. 31. Date filed (Month, Day, Year) State Registrar

1 ☐ Yes 2 ☑ No

1 X Natural

2 Accident

3 ☐ Suicide

4 Homicide

29b. Signature and title of certifier



28a. Date of Injury (Month, Day Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗀 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

D0033503

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

8-13-67

Llushand

5 Pending investigation

6 ☐ Could not be

determined

State of Maryland / Department of Health and Mental Hygiene [ ] 7 28173 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Burwell Sr. George Ε 9:08 P M August 14 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) , Funeral 1 J M 2 □ F Months Director 578-48-0543 73 North Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location or Items 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 1 √ Yes 2 No Director Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2208 Columbia Avenue 20785 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 2X No 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2√☐ No þ If Yes, Give Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other traumatic event, Item. Elementary/Secondary (0-12) College (1-4or 5+) 9th Fork Lift Operator Private other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Langdon Burwell Willie Mae Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Burwell/Wife 2208 Columbia Avenue Landover, Maryland 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 8/21/2007 Clinton, Maryland uneral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** odgulopathy disease or condition resulting in death) /Medical Examiner intravascular coagulation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-trar that initiated events and resulting in death) Last Due to (or as a consequence of) the ettending physicien hed for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown à signed b Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Diseare 1 Yes 2 No 3 Probably 4 tonknown peeu Ibenn wilner 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performe certificate 20 No 1 Yes 2 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Detural 2 Accident Injury n 24 hours after death.
he Funeral Director: A
bletely filled in by the fi 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Ecertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 0043662 je 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NILLAM 3001 Hospital Drive Cheverly, Maryland 20785 9 HOSB 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 2007 AUG 1 Registrar

DHMH 17 Rev 1/2001

			For State	State of Ma	•	partment of F ertificate of I				007	28174
	16		Registrar  1. Decedent's Name (First, Middle	e, Last)		ortinoato or .		2. Date of De	ath		3. Time of Death
	Physicia		Moshammet Shah	anara Begum				August	13, 2	2007 Year	1:57 A.M
	/Medic Examin		4a. Facility Name (If not institution			4b. City, Town, o	r Location of Death			ounty of Death	
	**		Shady Grove Ad			Gaithers		To Date of Die		ntgomer	-
	Funeral Director		5. Social Security Number 219–59–8018	6. Sex 7. Age	(In yrs. last birthd	Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Decemb	_{y, Year} , 90 er 20	Bang	place (State or Foreign Intry) 1adesh
k.º	D		Usual Residence of Decedent					7000		, ,	
	arylan show d at	r.	10a. State 10b. County		10c. City, Town or						10d. Inside City Limits 1 ☐ Yes 2 No
	he Ma 18a-f s	Director	Maryland   Montg	omery	Gaithers	10f. Zip Code		-	10a Citize	n of What Cou	
	a or 2		10e. Street and Number								
	ns 23	Funeral	8334 Tea Rose D	12. Was Decedent B	ever in U.S.	20879 3. Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Sp	ecify Yes or No		ladesh Race - Amer	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 Never Married 2 Marri 3 Widowed 4 Divorced	ied Armed Forces?  1 □ Yes 2 ▼ N  If Yes, Give  Year or Dates:	lo	1 ☐ Yes 2 No	Specify:	) Hican, etc.)	1	Black, White pecify: As	ian
5	"n 72 hou "natura edical E	Completed	15. Decedent (Specify only highes	st grade completed)	(G	ecedent's Usual Occup live kind of work done le. DO NOT use retired	oation during most of work d)	king	16b. Kind	of Business/l	ndustry
7	within iene. r than the M	duo!	Elementary/Secondary (0-12)	College (1-4or 5	+)	emaker	,		0wn	Home	
2	other /ent, 1	BeC	17. Father's Name (First, Middle,	Last)	1		18. Mother's Nam	e (First, Middle	, Maiden St	urname)	
ā	Menta Menta arked aric ev	10 E	Mohammed Manik	Khan			Sayera B				
0	12 sho h and is ma rauma		19a. Informant's Name/Relations		19b. M 83	ailing Address <i>(Street</i> 34 Tea Ros ithersburg	and Number or Ru e Drive	ral Route Numb	er, City or T	Fown, State, Z	ip Code)
ָ ט	1 and Healt em 2		A T M Golam Hos	ssain / Spous	20b. Place of Di	sposition (Name of crematory or other place	į	Date	20c. Loca	ation - City or	Town, State
	tment of tant: If It ant: If It or or or or or or or or or or or or or		1 Marial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)	Marylan	d National	Pk. 200	ust 13,	Laure	el, Mar	yland
0	permit Depar Impor any in		21. Signature of Funeral Service  Burn M	The MO:	1508	Thibadeau 933 Gist	Mortuary ve., LL,	Servic Silver	e. P.A Sprin	A. ng, MD	20910
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lir	the death. Do not ne.	enter the mode of dyi	ng, such as cardiac	or respiratory	ırrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Sepsis	a consequence of):						Hours
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O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐Ectopic pregnanc 5 ☐ Other (specify) _	у		23	3d. Date of del Month	ivery Day Year
Ļ	that the		Part II. Other significant condition	ons contributing to death b	ut not resulting in th	ne underlying cause giv	ven in Part I.	23e. Did	tobacco use	e contribute to	the cause of death?
2	quires en sig	ed by						1 🗆	Yes 2	No 3□Pr	obably 4 Unknown
ecords,	law re as bee 2 sho	Completed						24a. Was	psy	prior to	topsy findings available completion of cause of
	The ate ha	Com						perl 1□ Yes	ormed? 2 No	death? 1 ☐ Yes	2 No
N 1 2	Iclan; Sertific ector,	Be	25. Was case referred to medica examiner?	Hospital:	,	Ott	26. Place of Dea				
5	Physic this cral din	: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie		ident 3 DOA	4 □ Nursing H	lome 5 Res			cify)
	ding h. After	tion	1 Natural 5 Pendir 2 Accident investi	ng (Month, Da		ıry Wo	rkí? ]Yes 2∐No		,,		
DIVISION	or Attenter deat irector:	Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e Place of init	l ury - At home, farm c. <i>(Specify)</i>	, street, factory, office		28f. Location City or To	(Street and own, State)	Number or Ri	ural Route Number,
ב	lospital c hours af uneral D		29a. Certifier 1 X Certifyli (Check only 2 Medical	ng Physician: To the best Examiner: On the basis o	of my knowledge, of	leath occurred at the tor investigation, in my	ime, date and place	e, and due to the	e cause(s) a	and manner as	s stated. e to the cause(s)
	the H	Medical	one) 29b. Signature and title of certifie	and manner sta			se number			signed (Mont	
	P 8 8		290. Signatur ad the of certain					553			-
_	de		30. Name and address of person Patsy M. M.	who completed cause of d	eath (Item 23a) (Ty 9901	Medic	cal Cer	nter	Dr.	Rock	ville MD
	Sta Registi		31. Date filed Month, Day, Year, AUG 1 7 2007		ar's Signature						/
	9130			March M.	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 28175 For State Registra<u>2</u>06 & 20c Per fh gc,8/20/07 Amended # Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Ella August 14 2007 7:23 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Community Hospital Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗙 F 577-64-8544 Jan 29, 1946 Director 61 North Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☐ No Maryland | Prince George's Director Capitol Heights 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ns 23a or must be n 517 Carmody Hills Drive 20743 USA Funeral 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ö 1 ☐ Yes 2X No Specify: Specify: ģ Black 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook Government 7 is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luther Barnes Mollie Pender ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Daughter) Vanessa Barnes Health a 517 Carmody Hills Drive, Capitol Heights MD 20743 Department of Health Important; If Item 27 any injury or other troonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Brentwood Md. 1 Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial Park 8/24/2007 Landover, Maryland Ft. Lincoln Cm. 22. Name and Address of Facility Latimore Funeral Services, P.A. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur f Funeral Service Licer 9013 Annapolis Road, Lanham MD 20706 Approximate Interval Between Onset and Death 3 Years 23a. Part1. Enter the disease, or semplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive heart failure years Physician /Medical Due to (or as a consequence of): Examiner Uncontrolled hypertension Sequentially list conditions Examiner physician and s the burial-trans Physician/Medical Completed by Be

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: dompletely filled in by the

Baltimore, Maryland 21215-0036

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome pf pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3□Ectopic			23	d. Date of de Month	livery Day	Year
Part II. Other significant conditions of Asthma	contributing to death but not resu	ting in the underlying	cause given in Part I.		Did tobacco use			se of death? 4 ∐Unknown
					Was an autopsy performed?	prior to death?	utopsy fin completio	dings available n of cause of
25. Was case referred to medical			26. Place of De	ath (Check o	only one)			
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☑ I	R/Outpatient 3 I	OA Other: 4 Nursing I	Home 5□	Residence 6	□Other (Sp	ecify)	
27. Manner of Death  1  Natural 5  Pending 2  Accident investigation 3  Suicide 6  Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M me, farm, street, facto	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Desc	ribe how injury ion (Street and or Town, State)	occurred		e Number,
	nysiclan: To the best of my know							

29c. License number

DC 15632

1011 North Capital Street, NE, Washington DC 20002

29d. Date signed (Month, Day, Year)

8-14-07

State Registrar

ို

Medical Certification;

29b. Signature and title of certifier

31. Date filed (Month, Day, AUG 1 7 2007

Douglas Van Zoeren,

and manner stated

M.D.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 1:35 pм 2007 Hartwell Wilburn Byrd, Sr. August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Manor Care Montgomery Chevy Chase 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F 494-12-9608 December 17,1921 Missouri Director 85 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 1629 Hopefield Road 20905 U.S.A. Funeral 7 is marked other than "natural", or items traumatic event, the Medical Examiner m 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. e filed within 72 hours after al Hygiene. other than "natural", or ite 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🖺 No Specify II þ Specify: African-American 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Auto Body Technician Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tem 27 is marked ott Be Ernest Byrd Violetta Wallace ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Laura A. Wright - Granddaughter 12903 Eagle Creek Drive, Beltsville, Maryland 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of Hi
Important: If iter
any injury or ott
once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 08/20/2007 4 □ Donation 5 □ Other (Specify) Fort Lincoln Crematory Brentwood, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Immediate Cause (Final Physician Aspiration Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner C-Tube Feeding Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the death certificate be executed burial-transi Chronic Obstructive Pulmonary Disease attending physician and for use as the burial-tran tiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical Diabetes Mellitus the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 2 | No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Colon Cancer autopsy performed? 1∐ Yes 2**⊠** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only of a) Hospital: Other: 4 🖾 Nursing Home 5 🗀 Residence 6 🗀 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred I or Attending Paffer death. 1 X Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 □ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ithin 24 hours a the Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

AUG 1 6 2007

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kirti Vohra, M.D., 31. Date filed (Month, Day, Year)

7710 Bradley Blvd., Bethesda, Maryland 20817

D20274

August 1, 2007

			1- For State Registrar		partment of Health a ertificate of Death	nd Mental H	ygiene Reg. No. 200	7 28177
	Physici		1. Decedent's Name (First, Middle, Last)	bitt		2. Date of D	Death Day Yea	3. Time of Death
J.	/Medi Examir		4a. Facility Name (If not institution, give street and n	Death	4c. County of De	eath		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	Scalisbu (	4 Hrs. I 8. Date of B	Dav. Year)	Birthplace (State or Foreign
	Director		216-32-2368	71 10c. City, Town or L	ocation	Dec. 1	.8, 1935 M	laryland  10d. Inside City Limits
	ie Maryla Ba-f sho atifled al	Director	MD Worcester		Pines			1 □XYes 2 □ No
	h with th	al Dire	10e. Street and Number 113 Seafarer Lane		10f. Zip Code 21811		10g. Citizen of What	Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifled at once.	by Funeral	11. Marital Status  1 □ Never Married 2 Married  1 □ Never Married 2 Married  1 □ Yes	^{2 No} 1955-	. Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 No Specify:	in? (Specify Yes or N Puerto Rican, etc.)	14. Race - Ar Black, WI	
21215-0036	n 72 hours "natural" edical Ex	leted b	3 Widowed 4 Divorced Year or  15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occupation e kind of work done during most of DO NOT use retired)	of working	16b. Kind of Busines	White ss/Industry
1212	led withii lygiene. her than nt, the M	Completed		{ 1-40f 5+}	s Manager			e Company
Maryland	uld be fii Mental H irked otl	To Be	17. Father's Name (First, Middle, Last) Edward L. Corbitt			s Name (First, Middl C. Smit	le, Maiden Surname) h	
Mary	d 2 sho th and I 7 Is ma trauma	ľ	19a. Informant's Name/Relationship (Type. Print)		ling Address (Street and Number			
timore,	Pages 1 an ent of Heal nt: If item 2 y or other		Jeannette R. Corbitt/  20a. Method of Disposition  1	20b. Place of Disp cemetery, cre Round	ematory or other place) At	ıg. 29,	20c. Location - City of	or Town, State
Baltii	permit. F Departm Importar any Injur		21. Signature of Funeral Service Licensee		ry 22. Name and Address of Facility 9 S. Main St			tuary Inc.
)	Physician /Medical Examiner			caused the death. Do not er each line.	nter the mode of dying, such as co Parkin son's			Approximate Interval Between Onset and Death
58760, 5	ficate be executed graphysician and is the burial-transit	edical Examiner	days, (bisease or injury that initiated events of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the cour	(or as a consequence of):				
P.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as in age 2.	Physician/Me	in the past 12 months?	nant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of d Month	elivery Day Year
	w requires that s been signed b should be deta	þ	Part II. Other significant conditions contributing to a Dealestes	tobacco use contribute to the cause of death?  Yes 2⊠ No 3 □ Probably 4 □ Unknown				
Vital Records,		e Completed	25. Was case referred to medical		00 Pi	perf 1□ Yes	opsy formed? prior to death? 2 ♣ No 1 ☐ Ye	
DIVISION OF VI	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification: To Be	examiner?  1  Yes 2 No Hospital: 1   27. Manner of Death 1 Natural 5 Pending investigation 2 Accident (Mon	nth, Day Year) Injury	ont 3 DOA Other: 4 Nurs of 28c. Injury at Work? M 1 Yes 2 No	ace of Death (Check only one)  Nursing Home 5 ☐ Residence 6 ØOther (Specify)		
2	oital or A urs after eral Direc		4 ☐ Homicide determined 206. Flace built	e of injury - At home, farm, st ling, etc. <i>(Specify)</i>		City or To	(Street and Number or I own, State)	
	the Hosp in 24 ho the Fune upletely f	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the 2 ☐ Medical Examiner: On the and mai	e best of my knowledge, dea pasis of examination and/or in oner stated.	th occurred at the time, date and nvestigation, in my opinion, death	place, and due to the occurred at the time	e cause(s) and manner e, date and place, and d	as stated. ue to the cause(s)
1	Mith To	2	29b. Signature and title of certifier	Belle n	29c. License number  29c. 29c. License number	75-	29d. Date signed (Mo.	
•	15		38. Name and address of person who completed cau		, Print)			
P	Sta Registr		GREGORIO M. BELLO 31. Date filed (Month, Day, Year)  SEP 0 4 2007	Registrar's Signature	2 CHINABERR	-1 UK, 31	MISDURY	LID 5 ( A D )

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Dav **Physician** Richard Allen Cummings 14 2007 8:30 AM Aug /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Severna Park Anne Arundel Genesis Eldercare Severna Park If Under 24 Hrs. Hours Min. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) Funeral 1**X** M 2□ F Days Months 236-46-8067 74 Director West Virginia Aug 11, 1933 Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours effer death with the Meryland nent of Heatth and Mental Hygiene. snt: If Item 27 is marked other than "naturel", or items 23e or 28e-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County must be notified at 1 ☐ Yes 2 No **Funeral Director** MD Anne Arundel Arnold 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 487 Louise Lane 21012 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 (X)Yes 2 □ No If Yes, Give Korean Year or Dates: War 14. Race - American Indian, 11. Merital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 🛣 No Specify: Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Paper Company Electrician 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna B. Nestor James R. Cummings 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 231 Light Street Avenue, Pasadena, Maryland 21122 Wanda L. Neice/ Daughter Aug 17, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Depertment of important: If It Burial 2 Cremation 3 Removal from State MD Veterans Cemetery ò Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Injury Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licenses 495 Gov. Ritchie Hwy, Severna Park, MD 21146 fications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. 23a. Part1. Enter the disease, of shock, or heart failure. List Onset and Death Physician 600 quarros coll corcinmo offin /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner eral Director: After this certificate has been signed by the attending physician end filled in by the funeral director, page 2 should be deteched for use as the buriel-transit Hospital or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 76s 2 No 3 Probably 4 Unknown 24b. Were autopsy findings 24a. Wes an autopsy performed? available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ↓ ursing Home 5 ☐ Residence 6 ☐ Other (Specify) **≯** No 1 Yes 27. Manner of Leath 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as steled.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steled. completely (Check only one) 29b. Signature and title of completed ceuse of death (Item 23e) (Type, Print) 30. Name and address of person 2108 9 G 32. Registrar's Signature 31. Date filed (Month, Dey, Year) State

Registrar

		1 - For State Registrar	State of Maryl		rtment of I tificate of		Reg	200	7 28179
Physici	an	Decedent's Name (First, Middle, Last)     Maude Lucille Cyp					2. Date of Death Month	Day Year	3. Time of Death
/Media	al	4a. Facility Name (If not institution, give			41. 01. 7		August	13,200	
Examin	er	SALISBURY REHAB	& NURSIN		SAL		MD. 21804		COMICO
uneral irector		5. Social Security Number 6. Sec. 225-32-1878	7. Age (In)	yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, You Dec. 11,	1908 Vi	irthplace (State or Foreign Country) Cginia
Mon to		10a. State 10b. County	10c.	. City, Town or Lo	ation				10d. Inside City Limits
r 26a-f show nytified at	Funeral Director	Maryland Wicomico	Sa	alisbury	104 Zin Code		10-	Citizen of James of	1 X Yes 2 □ No
alte	<u>ā</u>	200 Civic Avenue			10f. Zip Code 21804		109	. Citizen of What C USA	country?
	nera		12. Was Decedent Ever i	n U.S. 13. V		Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No-	14. Race - Am	nerican Indian,
	by	1 ☐ Never Married 2 ☐ Married 3 🔯 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Yes, specify Cub □ Yes 2X No		to Rican, etc.)	Black, Wh	oite, etc. White
	Completed	15. Decedent's Edu (Specify only highest grade	completed)	16a. Deced (Give I	ent's Usual Occup ind of work done O NOT use retire	pation during most of world)	rking 16l	o. Kind of Busines	s/Industry
	E O	Cionionally/Socondary (0-12)	College (1-4or 5+)	Mana				Hote1	
	To Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle, Mai	den Sumame)	
1	2	Frank Lowe					Mae Nipper		
		19a. Informant's Name/Relationship (Ty)					ural Route Number, C		
		Shirley Manning/Day 20a. Method of Disposition		b. Place of Dispos	ition (Name of		Salisbury	. Location - City o	
		1 Burial 2 □ Cremation 3 NR 4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, crem	atory or other pla				
DUCE.		21. Signature of Funcial Service Lidence		New Chape		-			,Mississippi
		N Resumed X	Salle	Zel	ler Fune	eral Home	P. O. Bo	x 3171	MD 21802
		3a Part 1 Enter the disease, or comples shock, or heart failure. List only on	cations that caused the d	eath. Do not ente	r the mode of dyir	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between
		Immediate Cause (Final disease or condition	a cause on each inne.	Ric 12	625	D,-			Onset and Death
		resulting in death)	Due to (or as a cons	sequence ef):					gear
ı	_	Sequentially list conditions, b	Joy cg	then	cal	Vera			geen-
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to for as a cons	sequence of):				/	1
	xar	that initiated events cresulting in death) Last	Due to (or as a cons	sequence of):					
l	cal								
				= 2					
l	an/N	230. Was decedent pregnant	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy	,		23d. Date of de	elivery
	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of		Other (specify)	,		Month	Day Year
	by P	Part II. Other significant conditions con	tributing to death but not	resulting in the un	derlying cause giv	ren in Part I.	23e. Did tobac	co use contribute t	to the cause of death?
							1 🗆 Yes	2 <del>3 √</del> 7 3 □ F	Probably 4 Unknown
	Completed						24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
	E						performed	death?	s 2 No
		25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one)		
	၉	1 Tes 2 No H		ER/Outpatient	3□ DOA Oth	4 Mursing H	ome 5 Residence		ecify)
	Certification:	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 1	yat k? Yes 2 ∐ No	28d. Describe how i	njury occurred	
	Sertifi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre ecify)	et, factory, office		28f. Location (Stree City or Town, S	t and Number or F tate)	Rural Route Number,
	Medical (	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin	ician: To the best of my ser: On the basis of exam and manner stated.	knowledge, death ination and/or inve	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	, and due to the cause rred at the time, date	e(s) and manner a and place, and du	as stated. se to the cause(s)
	Me	29b. Signature and title of certifier	10		29c. Licens	e number	29d.	Date signed (Mon	nth, Day, Year)
		1000	1/2-		0	2170	08 8	1 /1 -	
		30. Name and address of person who cor	npleted cause of death (I	tem 23a) (Type, P	rint)	1-1	1 1	101	-

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Anthony Caruso 14,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George's Doctor's Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Wash, DC Months Days 11√ M 2□ I 719-16-3699 85 June 8, Usual Residence of Decedent 10a State 10h County 10c, City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Prince George's Colmar Manor Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20722 4207 Newton Street USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 28 Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Agriculture 12 Realty Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Santo Diguilmi Micheli Diguilmi ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida E. Caruso/Wife 4207 Newton Street, Colmar Manor, MD 20722 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Buria! 2 ☐ Cremation 3 ☐ Removal from State Aug. 20, 2007 Cedar Hill Cemetery Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MANULL Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pronie Devitable 1000 Due to (or as a consequence of): Sequentially list conditions, than, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an

**Physician** /Medical Examiner

**Funeral** 

Director

a or 28a-f show be notified at

Items 23a

"natural", or

is marked other

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau
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Medical

Division or Vital Records, P.O. Box 68760,

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

To the within 2

AUG 2 0 2007

29b. Signature and title of certifier

tables out of mo 750 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

			For State Registrar	State of Maryland	•	it of Health and Me of Death	lental Hygie	2001	28181
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last  Over S  4a. Fecility Name (If not institution, give	Monroe	Conaw 4b. City,	O //	2. Date of Death Month August	Day Year <u>09, 2007</u> 4c. County of Death	3. Time of Death
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Baltimore,	permit. Peges Depertment of Important: If i eny injury or once.		1 Ø Burial 2 Cremation 3 di 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens	Hug	22. Name an	J Cometery 8/1 nd Address of Facility Funeral Ho	Me, P.A.	unbridge	MD.
	Physician /Medical Examiner	ner	23a. Pank Enter the disease, or compshock, or heart failure. List only disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	one cause on each line.	h. Do not enter the mod	E/	S+, Cat or respiratory arrest,	VIET 1 GG	Approximate Interval Between Onset and Death
68760,	eath certificate be executed ettending physicien and for use as the buriat-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	uence of):				
. Box	9 9 5	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	I death 3 □Ectopic pr			23d. Date of delive Month	ory Day Year
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			30. Name and address of person who con NUMAN TITANU		1 23a) (Type, Print)	SE CAMPRI	bee t	10 216.	/3
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Physician Medical Examinor    Physician Medical Examinor   Physician   Physici				23a. Part1. Enter the	disease, or o	complicat	ions that o	aused the	death. De									DO	Approximate	
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Bahram Pishdad, M.D. 1328 Southern Avenue, SE, Washington, DC 20032	12		_	PEM	1000						D.	51520	)			8/	10/20	007		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  Registrar AUG 1 6 2007 Figure 4.	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	1		Bahram P	ishdad							e, SI	E, W	ashin	gton,	DC	2003	32		
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	1.8		Registrar  1. Decedent's Name (First, Middle, La	ust)		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2. Date of Deat		3. Time of Death
#	Physicia /Medic		Elsie 1	)adl	,	4b. City, Town, or	Longtion of Dog	Month O 8	14 200/ 4c. County of Deat	7 3:15/4 1
	Examin	er	4a. Facility Name (If not institution, gir Shady (Trova Nu	zing and Reha	6	Rockvil	lle, M	D	Moutgon	0
	Funeral Director		577-22-9425	Sex 7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. Birt	hplace (State or Foreign Unitry)
	show	٥ľ	Usual Residence of Decedent  10a. State  10b. County  10a. Manual County	<b>1 1 1 1</b>	Town or Loc	. 11				10d. Inside City Limits 1  Yes 2  No
	with the M a or 28a-f be notifie	Funeral Director	10e. Street and Number	MELY NOC #412 AKDEN CIRCLE	<u> </u>	10f. Zip Code	750	1	0g. Citizen of What Co	untry?
	death vens 234	neral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	6. 13. V	1000	lispanic Origin? (S	Specify Yes or No-	14. Race - Ame Black, Whit	
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	1 and 2 shou Health and M em 27 is mai		19a. Informant's Name/Relationship  M. TON W. DAGE	(Type. Print) - HUSOANA	19b. Mailin	g Address (Street	and Number or 6	iural Route Numbe	RuckillE	Zip Code) Md 20850
Baltimore,	permit. Pages 1 and 2 Department of Health i Important: If item 27 is any outper tra		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Special Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control	Removal from State	lace of Disponentery, crem	sition (Name of matory or other place	ON NEW 8-	Date 17-2001	20c Location - City or	Town, State
Balti	permit. Pa Departmer Important:		21. Signature ( Barris Servic ) Co	ensee	13	Name and Addre	ess of acility	est NW	Washingto	N. DC20011
			23a. Part1. Enter the disease, or cor shock, or heart failure. List onl	polications that caused the death one cause on each line.	. Do not ente	er the mode of dyir	ng, such as cardia	ac or respiratory arr	rest,	Approximate Interval Between Onset and Death
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Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	Ideath 3	Ectopic pregnanc Other <i>(specify)</i>	у		23d. Date of de Month	livery Day Year
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<b>\</b>	To the within Co the comple	Me	29b. Signature and title of certifier	ng MD		29c. Licens	se number		29d. Date signed (Mon	th, Day, Year)
•	ge		30. Name and address of person wh	o completed cause of death (Item	23a) (Type,		kd.	-208. R	Lockville	MD
	Sta Regist	ate	31. Date filed (Month, Day, Year)  AUG 1 7 2007	32. Registrar's Signat		4 01,000		V	,	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #5, perInf, g871, 9/5/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 8:34 pM Jaronza Hiram Ellis 2007 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1⊠M 2□F <del>293-</del>64-9338 South Carolina Director August 16, 1942 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ä "natural", or items 23a or 28a-f sh dical Examiner must be notifiled 1 ☐ Yes 2 ☑ No Director Silver Spring Maryland Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9200 Compton Street 20901 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1⊠Yes 2□ No If Yes, Give Year or Dates: 1964-1974 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify Specify þ 3 Widowed 4 Divorced Black. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Military Service Major 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Inez Lavonia Laney James Henry Ellis 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra Lucille L. Ellis - Spouse 9200 Compton Street, Silver Spring, Maryland 20901 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cheltenham Maryland State
Veterans Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 図 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/20/2007 Cheltenham, Maryland 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licens e 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 020 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failule. List only one cause on each line. Do not enter the mode of dying, such as cardia or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but got resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

Pages 1 and 2 should be filed vent of Health and Mental Hygient: If item 27 is marked other t

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law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, physician the attending p þ signed by cate has l certificate this After the Hospital or Attending hin 24 hours after death. within 24 hours after community to the Funeral Director: Aft

2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

one)		wealcai	LXammer		a
29b. Signature	and tile	of certifie	r	_	

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and ad ws of person who completed cause of death (Item 23a) (Type, Print)

Nasreen Mustafa Kango, M.D., 7610 Carroll Avenue, Suite #205, Takoma Park, Maryland 20912

Registrar

Medical

31. Date filed (Month, Day, Year) AUG 1 6 2007



			For State Registrar	State o	of Marylai		artment <i>rtificate</i>				/lental Hy		200	7	2818	5
		H	Decedent's Name (First, Middle)	e, Last)		·					2. Date of De	eath			3. Time of Death	
	Physicia /Medic		Jeanne	B. Fe	ssler						Lugie	IT Da	16 20	ear Vo 7	6:00 AN	I
	Examin		4a. Facility Name (If not institution	_			4b. City, T	own, or	Location	of Death		40	. County of			
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3	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da Jul 23	rth a <i>y, Year</i>	30	. Birthpl Coun	ace <i>(State or Foreig</i> try) Jersey	n
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$\mathcal{F}_{\mathcal{M}}$ Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Address	(Street a	and Numb	er or Ru	ral Route Numb	er, City	or Town, S	ate, Zip	Code)	_
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plete	Σ	29b. Signature and title of certifier		29c. Licen	se number	29d.	Date signed (Mont	h, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wicomico HOSDICE at the Lake If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. castal Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗷 F Months 222-30-9131 60 **Director** WHALEYVILLE, MD JUL 03, 1947 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director DELAWARE SUSSEX COUNTY **MILLSBORO** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with BRANDYWINE APT. 103, MONROE ST. 19966 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC LABORER 10 HOTEL/MOTEL INDUSTRY Pages 1 and 2 should be filed nent of Health and Mental Hygint: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LENFORD HANDY MARGARET SAVAGE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

BRANDYWINE APT 103; MONROE STREET 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau MICHAEL HANDY MILLSBORO, DELAWARE 19966 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ZOAR GOLDEN ACRES AUG. 24,2007 BISHOPVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MO 1365 WATSON FUNERAL HOME, MILLSBORO, DE 19966 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARCINOMA OF LYNG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, many, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for each consequence of Examiner the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the sid be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, þ 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform this certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 🕏 🕏 2 ER/Outpatient 3 DOA ဥ 27. Manner of De th 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred After Certification: Division (Month, Day To the Hospital or Attending Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and fittle of certifie 29c. License number DO058410

BAZ

State 31. Date filed

31. Date filed (Month, Day, Year)

AUG 2 1 2007

HUMM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WARG



8.0 Box 1733 , SALIS BULL MD 21802

			For State Registrar		State	of Mary	/land		rtmen			and M	-	giene Reg. No		n 7	28	188
	Physici	an	1. Decedent's Name	,	Last)							1	2. Date of De Month	ath Day	,	Year	3. Time	of Death
To the	/Medic	al .	John R. G		aive street and	number)			4h. Citv.	Town, or	Location of		Augus			007 of Death	05:	04A M
	Examin	ier	Berlin Nu				er		Berli		Location	Journ				ster		
	Funeral		5. Social Security No		5. Sex 1 <b>X</b> M 2□ I	7. Age (Ir			If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)		9. Birthp	lace (State	e or Foreign
	Director		163-09-31 Usual Residence of		IA: IVI 2L. I	9	95	Yrs.					11/7/1	911			PA	
	yland now at		10a. State	10b. County		10	c. City, T	own or Lo	cation							1	0d. Inside	City Limits
	e Mar 3a-f sk tiffied	Director	MD	Worce	ester		000	ean P	ines									es 2⊠No
	a or 2	D I	10e. Street and Nun		,				10f. Zip							/hat Coun	try?	
	leath ns 23	Funeral	54 Windja	ammer Ko	12. Was D	ecedent Ever	r in U.S.	13. V		811 ent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)		SA 14. Race	- Americ	an Indian,	
9	after o or iter miner		1 Never Marri	ied 2 Marrie	d 1 □ Ye	Forces?			fYes,speo I∐Yes 2			i, Puerto F	Rican, etc.)			k, White,		
R. 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 Widowed		1 1 1 1 1 1 1 1 1	Give or Dates:		16a. Deced						105 K		Whi		
-5-	in 72 n "nat Aedica	Completed		15. Decedent's	grade complete		-1	(Give life. L	kind of wor DO NOT us	k done d e retired	during mos )	t of workin	ng	100. K	ria oi bu	siness/Ind	lustry	
R.	filed withi Hygiene. other than ent, the M	E C	Elementary/Secon	ridary (0-12)	Colleg	e (1-4or 5+)	$\perp$	Engi	neer					E	ngin	eeri	ng	
hn Ind	ed d all	Be	17. Father's Name (		,								(First, Middle			e)		
John <b>ryland</b>	2 should be f n and Mental i is marked of raumatic eve	2	Harry Kr				-	10h Mailin	a Addraes	/Street			ephine   Route Numb			Stata Zin	Codo	
Gamble, John altimore, Maryland	and 2 s ealth an n 27 is i		Sherry Ga		, , , , ,		į		•				n Pine			. ,	ocac)	
Gambl imore,	es 1 and 3 of Health fitem 27 rother tr		20a. Method of Disp				20h Plac	e of Disponetery, cren	sition (Nan	ne of			ate				wn, State	
Gar	Pages ment of tant: If it jury or o	١,		5 ☐ Other (Sp		om State	Саре	Hen1	_		·	3/20/				rd,	DE	
Ball	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any Injury or other traumatic once.		21. Signature of Fu	ineral Service L	censee	each	/						bage F					
			23a. Part . Enter the shock, or hea	he disease, or o	nly one cause of	on each line.				-	•		•				Approxin	nate Between
	Physician		Immediate Cause ( disease or condition resulting in death)	Final n		Theres			Caro	lobi	ld= cu	der	Disc	us e			Onset ar	Ma Death Main Death
	/Medical Examiner	П	,	- 1	Due	to (or as a co	onsequer	nce of):										
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	ecutec and transi	Examiner	Cause (Disease or that initiated events resulting in death) L	j	c	to (07.00.0.0												
8760,	ate be executed hysician and the burial-transit	ical Ey	,	1	, Due	to (or as a co	onsequen	ice oi).										
687	ifficate g phys as the				d									4				
ŏ	death certific attending p	an/M	IF FEMALE: 23b. Was decedent			outcome pf p			Ectopic pr	eanancv	,			55		e of delive	,	V
О.	Attending Physician: The law requires that the death certificate be executed riceath.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	4□P:	regnant at tim nknown			Other (sp						Mor	ntn	Day	Year
o.	w requires that the dibeen signed by the should be detached		Part II. Other signif		s contributing t	to death but n	ot resultir	ng in the ur	nderlying c	ause give	en in Part I		23e. Did	tobacco i	use contr	ribute to th	ne cause o	of death?
rds	quires in sign	ed by											1 🗆	Yes 2	□ No	3 Prob	ably 🏂	Unknown
ဝပ	ne faw re has bee ge 2 sho	Completed											24a. Was		24b. V	Were auto	psy finding	gs available of cause of
<u> </u>	sician: The certificate ha rector, page	S S											perfe 1∐ Yes	ormed?	0	death?	2 □ No	
Vita	sician: Th certificate rector, pag	B B	25. Was case reference examiner?		Hospital:					. Othe			(Check only					
ō	y Phys er this eral dir	7: To	1 ☐ Yes 2 2 27. Manner of Deat		28a. D	☐ Inpatient ate of Injury	28	8b. Time of		8c. Injun Work	4 7 81		ne 5 Res 28d. Describe				y)	
io	ath. arh. or: Afte	atior	1 Anatural 2 ☐ Accident	5 ☐ Pending investiga	tion	Month, Day Ye	ear)	Injury	М		<br Yes 2□	No						
Division or Vital Records, P.O. Box 6	2 = 2 = 0	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	200. F	lace of injury uilding, etc. (5	- At home Specify)	e, farm, str	eet, factory	, office		2	28f. Location ( City or To	Street ar wn, State	nd Numbe e)	er or Rura	l Route N	umber,
	To the Hospital or within 24 hours after To the Funeral of completely filled in it.	Medical C	29a. Certifier (Check only one)		Physician: To xaminer: On the		amination											e(s)
	To the within To the comple	Me	29b. Signalus and	title o certifier		Tigrillor states					e number						Day, Year	
			WIN	de	uh	- 6	~~	2	6	26	185	69		8	12	ole	7>	
- B	AID		30. Name and addr Wicholes	1	no completed o	_	h (Item 23	3a) (Type, <b>2</b> 0 <b>9</b>	Print)	UH	Lyhn	سر آ	Ferwie	大开	land	e De	19	न्यप्
Ĭ		ate	31. Date filed (Mon	oth, Day, Year)		2. Registrar's	Signatur	e U	6.0		1	1				1		

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aylor dadralo.		For State egistrar	i Mai yiana i D	•	te of Dea		Wichta	,,,	200	7 2818
Physician	1	. Decedent's Name (First, Middle,Last)	a !					2. Date of Death Month	Day Year	3. Time of Death 1632 hrs
Medical Examine		Taylor Joseph  a. Facility Name (if not institution, give s	Gaertner		4b. City	, Town, or Lo	ocation of D	August 14,	4c. County of Death	
		TRiple Crown Rd. & Triple C			Bov	vie			Prince George	e's
Funeral Director			7. Age (In	yrs. last birth	Mon Yrs.	nder 1 Year oths Days	If Under 2	Min	12, 1982 Co	
	-	Usual Residence of Decedent  10b. County	100	. City, Town o	Location					10d. Inside City Limits
and show ance.	5	MD Prince G	eorge's	I	Bowie					1 X Yes 2 No
death with the Maryland or items 23a or 28a-f show any must be notified at once.		0e. Street and Number 13506 Steeplech	ase Drive			Zip Code 2071		-45	g. Citizen of What Coul USA	
		1 XNever Married 2 Married 3 Widowed 4 Divorced If	12. Was Decedent Eve Armed Forces? 1 Yes 2 X Yes, Give Year or Dates:		If Yes, spe	dent of Hispacify Cuban, I	Mexican, Pu	( Specify Yes or No- verto Rican, etc.)	White, etc.	ican Indian, Black,
	ם ביים	15. Decedent's Education (Specify only	highest grade complet		ecedent's Usu				16b. Kind of Business/	Industry
5-0036 ed within 72 hour lygiene. other than "natt		Elementary/Secondary (0-12)	College (1-4 or 5+)			dent	31		Education	1
5-00 ed with	5	7. Father's Name (First, Middle, Last)	-		Dea		8.Mother's N	lame (First, Middle, M		
21215-0036 21215-0036 Suldbe filed within 7 Mental Hygiene. marked other than ite event, the Medica	ן מ	Richard Lawrence		r				een Sue M		
Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur injury or other trainmatic event, the Medical Exam	1	9a. Informant's Name/Relationship (Typ Richard L. Gaertne			Mailing Addre				ie, MD。2	20715
e, K		20a. Method of Disposition		20b. Place of	Disposition (N	lame of ceme		Date	20c. Location - City or	
Baltimore, permit, Pages 1 ar Department of Hee Important: If ite Injury or other tr		1 XBurial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State			,		8/18/2007	Rockville	e, MD.
Salti ermit. epartm nports ijury o	- 1-	21. Signature of Funeral Service License	e						Rockville eral Home	
Physician		3a. Part I. Enter the disease or complic	ations that caused the	death. Do not		NW Cra				20715 Approximate Interval
/Medical Examiner		failure. List only one cause on each mmediate Cause (Final disease a. C		Vound of H						Between Onset and Death
red nisit		Sequentially list conditions, fany, leading to immediate auss. Enter Underlying Cause Disease or injury that initiated c	ue to (or as a conseque	ence of):				10-1-1		24
760, icate be executed physician and the burial - transit		events resulting in death) Last Du	ue to (or as a conseque	ence of):		<del></del>				
'60, ate be execu bhysician and burial - tra			AMENDED	f promoneu					23d. Date of deliver	
ox 68 ath certificate certifications or use as	2 Clall	F FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome o  Live birth  Pregnant at time  Unknown	2	Fetal dea		Ectopic pr	egnancy		y Day Year
O. BC at the dea		Part II. Other significant conditions		t not resulting	in the underlyi	ing cause giv	ven in Part I		bacco use contribute to	
ires that the signed by the detache	2							1 Yes	2 <b>V</b> No 3 Pro	bably 4 Unknown
Division of Vital Records, P.O. pital or Attending Physician: The law requires that thours after death.  seral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach.	naldillo					<u></u>	-	24a. Was a autops perform	sy prior to med? death?	utopsy findings available completion of cause of es 2 No
cian: certifi	ע פ	25. Was case referred to medical examiner?	spital:				)th on :	neck only one)		
of Vi ing Physi After this funeral dia	- 1-	1 Yes 2 No	28a Date of Injury		me of Injury	3 =	at Work?		Residence 6  Othe	r; Scene
Division o spital or Attending hours after death. neral Director: After filled in by the fune	Cation	1 Natural 5 Pending Investigation	FOUND:	FOUN 1629	hrs	100	es 2 V N			ural Route Number, City
Divi		3 Suicide 6 Could not be determined	(Specify) Wood	s				or Town, St Triple Crown F	ate) Rd. & Triple Crown D	rive, Bowie, MD
Divisior  To the Hospital or Attend  To the Funeral Director: Completely filled in by the		one) 2 Medical Examiner: 0			estigation, in	my opinion,	death occur		e(s) and manner as star and place, and due to the	ne cause(s)
(2)	Ē :	29b. Signature and title of certifier	٠		12	29c. License O.C.N			29d. Date signed (Mo August 15, 2007	
		00. Name and address of person who co Ana Rubio MD. Assistant	mpleted cause of death		enn Street	, Baltimor	re, MD 21	1201	<u> </u>	***************************************
Stat	~	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	1 .	,				
Registra DHMH 17 Rev 1/200		AUG 1 6 200	Daver	ر <i>ــــال ـــ</i> ـــا	<i>Golde</i> GINAL					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** ANDREW GORDON GORSKI 19 2007 7:15 P M AUG /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Months Days 1図M XX JULY 15, 1913 PENNSYLVANIA Director 176-32-2866 94 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits VIRGINIA FAIRFAX ALEXANDRIA 1 TYes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8352 ORANGE COURT 22309 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Payes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify þ Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OFFICER U.S. ARMY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 STANLEY GORSKI ANNA CASIMIR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID GORSKI / SON 7418 JENNA RD SPRINGFIELD, VA 22153 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NATIONAL NOV.19, 2007 ARLINGTON, VA 22. Name and Address of Facility DEMAINE FUNERAL HOME 21. Signature of Funeral Service Licensee Diana L. Downey 520 S. WASHINGTON STREET ALEXANDRIA, VA 22314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on earn line. Immediate Cause (Final **Physician** PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has e 2 autopsy perform certificate 1□ Yes 2 No To the Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this After thi funeral 27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the fi 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2007 8 01054801A (IN) 36. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL D. G. HAWK LCDR MC USN BETHESDA MD 20889-5600 32. Registrar's Signature Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

AUG 2 0 2007

07-06520 James Earl Goldsberry Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 28191

		For State				Certific	ate of	Death					Reg. No	)		
Physician edical Examine	/ 1	. Decedent's Name (First, Midd	e,Last) <b>Ear1</b>	Go1	dsber	ry						Date of De Month August 2	23, 200	07		3. Time of Death 0520 hrs
	4	a. Facility Name (if not institution 3051 Victory Lane #1		treet and nu	imber)		41	b. City, To Suitlan		ocation of	Death			c. County o	eorge	e's
Funeral Director	5	579-62-4458	6. Sex	2 F	7. Age (In <b>57</b>	yrs. last bii	rthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24Hrs. Min.	8. Date of E			Foreig	rthplace (State or gn puntry) <b>Virginia</b>
, any	-	Usual Residence of Decedent  Oa. State 10b. County	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		100	. City, Towr										10d. Inside City Limits 1 X Yes 2 No
Aaryland 28a-f show	٦		ice G	eorge	s	Sui	tland		Dada .				10a C	itizen of Wi	nat Cou	untry?
ith the Maryland 23a or 28a-f sho	Director	Oe. Street and Number  3051 Victor	y La	ne; A	pt. 1	.02			0746			Y I	Uı	nited	Sta	ates
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after al", or	à-			Yes, Give Ye			na1 Deceden	Yes 2	X No	specify:	and of the	aric dano	166	Specify: . Kind of Bu		
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** KATHERINE IRENE HALL 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ursing 8. Date of Birth (Month, Day, Year) 8/19/1916 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 D F Min 218-40-1181 91 Director Maryland Usual Residence of Decedent 10c. City. Town or Location 10a State 10h. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD. Harford Forest Hill 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code death with 1331 Cooptown Road 21050 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify. 3 Widowed 4 □ Divorced Black Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 Domestic Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Britton Joshu ို Janie Gorden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21034 19a. Informant's Name/Relationship (Type. Print) Frances L. Bond (Daughter) 1900 Franklin Church Rd. Darlington, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 8/30/2007 Forest Hill, MD. Fairview Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jarrettsville, Maryland Hlacklen Kurtz & Son Funeral Home, E.G. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ocardial A cule arction **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 5 Other (specify) After this certificate has been signed by i funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death. Or the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient P 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 32609 2710 Win en MD

State Registrar 31. Date filed (Month, Day, Year)

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Haure De Grace Mad 21078

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MILTIAM MY 1106 R

32 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🛛 F Months 86 Nov 07, 214-16-3235 1920 Mississippi Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo ns 23a or 28a-f sh must be notifled MD Anne Arundel Severna Park Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code USA 105 Round Bay Road 21146 Funeral death ral", or items 2 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of health and Mental Hygiene. and the firen 27 is marked other than "natural", or iten any or other traumatic event, the Medical Examinearry or other traumatic event, the Medical Examinearry or other traumatic event, the Medical Examinearry or other traumatic event, the Medical Examinearry or other traumatic event, the Medical Examinearry or other traumatic event, the Medical Examinearry or other traumatic event, the Medical Examinearry events are supported to the medical Examinearry events and the first events are supported to the first events and the first events are supported to the first events and the first events are supported to the first events and the first events are supported to the first events and the first events are supported to the first events and the first events events are supported to the first events and the first events events are supported to the first events are supported to the first events and the first events are supported to the first events are supported to the first events are supported to the first events are supported to the first events are supported to the first events are supported to the first events are supported to the first events are supported to the first events are supported to the first events are supported to the first events are supported to the first events are supported to the first events are supported to the first events are supported to the first events and the first events are supported to the first events are supported to the first events are supported to the first events are supported to the first events events are supported to the first events are supported to the first events events events are supported to the first events events events events events events events events events events events events events events events events events events events events events events events events events events events events events events events events events events events events events events events events events events e 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Doctor's Office Office Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Davis Jenny Anderson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Capitola P. Bradshaw/ Daughter 635 Ravine Road, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) August 16, 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 2007 Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Furieral Service License Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 1Bemso Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ORSTRUCTIVE Physician CHRONIC MRUAY DIJEMSE WEEKS resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence of Examine Due to (or as a consequence of): attending physician al for use as the burial-1 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RENAL 1 Yes 2 No 3 Probably 4 Unknown CHROWIC ATRIAL FIBRILATION 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy INTETINAL 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 After this after death. To the Hospital within 24 hours at To the Funeral D

(Month, Day Year) 5 Pending investigation 1 Natural 1 TYes 2 TNo 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 1 7 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 28194 Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Month **Physician** AUG. 15. 10:35 A ^M **JAMES** Ε. HARRIS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE COUNTY TOWNSON GILCREST HOSPICE HOUSE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 2-22-38 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 M 2□F WASH., DC 69 579-50-5953 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 X Yes 2 □ No BALTIMORE MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21215 3000 TOWANDA AVENUE # 316 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Y Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ö 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)
4 YEARS Elementary/Secondary (0-12) PHYSICAL EDUCATION TEACHER BALTIMORE SCHOOLS ould be filed w Mental Hygier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HARRIS, SR. LESTER DOROTHY WILLIAMS Pages 1 and 2 should nent of Health and Men 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15050 SIXES RD. EMMITSBURG, MD 21727 BEATRICE H. REAVER /DAUGHTER Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of
Important: If It
any injury or o HARMONY MEMO. PARK 8-21-07 LANDOVER, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. 21. Signature of Funeral Service Licensee WASH., DC 20002-5236 524 - 8TH ST N.E. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** HSPIRATION DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burjal-tra Due to (or as a consequence of). physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform or Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOS PICE 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Director completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1) Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number D64395 AUGUST 15, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUE DOBERMAN, MO 6565 NCHARLES ST. SUITE 216, TOWSON, MD 21204

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

AUG 2 0 2007

32. Registrar's Signature

Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any page injury or other traumatic event, the Medical Examiner must be notified at once.	n/ ner	Acquistrar  1. Decedent's Name (First, Middle,L Manuel Sc  4a. Facility Name (if not institution, a Ridge Road and Storm I	oto Herna	ndor							g. No.		
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Director			Orive			4b. City, Tov	S-	Hanove	Death E <b>r</b>		4c. County Anne A	rundel	
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the Maryl a or 28a-f tified at o	Ī	10a. State 10b. County	rundel		Town or Locat Hanove								10d. Inside City Limit
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21215-0036 suld be filed within 7 Mental Hygiene. marked other than c event, the Medica	B	17. Father's Name (First, Middle, Le Reynaldo Sot	o Carpio							First, Middle, M la Hei	laiden Surnam	ne)	aldivia
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Physician		23a. Part I. Effer the disease, or co failure. List only one cause on	mplications that caused	the death.	PH 92 Do not enter t	IILIP 241 Co	D. I Lui lying, si	RINA nbia uch as card	LDI Bl	FUNEI vd_Si espiratory arre	RAL SE Lver S est, shock, or h	RVI Spri	CE, P.A.  ng Md209  Approximate Interv  Between Onset an
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ted Insit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.  Due to (or as a consect.				121						
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	ysician/N	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcor  1 Live birth 4 Pregnant at  g Unknown		2 Fe	etal death ther (Specify	3 [	Ectopic p	regnand	су	23d. Date Month		ry Day Year
Records, P.O. Box The law requires that the death create has been signed by the atte page 2 should be detached for ur	ģ	Part II. Dther significant condition	s contributing to deat	h but not re	esulting in the u	underlying ca	use giv	en in Part	I.	1 Yes	2 🗸 No	3 Pro	
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Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

Certification: To ours after death.

neral Director: A
filled in by the fu 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier To the Hosp within 24 hou To the Fune completely fil Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) uluan o D 28079 August 14, 2007 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Francine Higgs-Shipman, M.D., 1355 Piccard Drive, Suite 100, Rockville, MD 20850

State Registrar 31. Date filed (Month, Day, Year)

AUG 1 7 2007

32. Registrar's Signature

	1 - State Registrar				Department of I Certificate of			eg. No. O A O T	2010
n	1. Decedent's Nan	ne (First, Middle, La	ast)				2. Date of Deat Month		3 Time of Dean
i			OLDER, JR.				August	11, 2007	0036
er	4a. Facility Name ( Prince  5. Social Security I	e 6 ev		Ortal e (In yrs. last bir	thday) If Under 1 Year	or Location of Death	8. Date of Birth	4c. County of Death Prince  9. Birth Cou	Secrets place (State or Forei
	579 82 Usual Residence	6917	YAW ZUI	45	Yrs.		MAY 23,	1962 NORT	H CAROLIN
_	10a. State	10b. County		10c. City, Tow	n or Location				10d. Inside City Limit
Director	MD 10e. Street and Nu	PRINCE	GEORGES	FORT	WASHINGTON		1	0.000	XXYes 2□N
		ORTH STAR	DRIVE		10f. Zip Code 2074	<i>t. t.</i>	"	0g. Citizen of What Cou	•
Funeral	11. Marital Status	JKIII DIAK	12. Was Decedent 8	Ever in U.S.	13. Was Decedent of I		pecify Yes or No-	UNITED STA 14. Race - Ameri	can Indian,
by Fu	1 ☐ Never Mar	ried XX Married	Armed Forces? 1 ☐ Yes ② If Yes, Give Year or Dates:	No	If Yes, specify Cut		o Rican, etc.)	Black, White,	ACK
		15. Decedent's E	ducation	16a.	Decedent's Usual Occu	pation	- 1	16b. Kind of Business/tr	
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Place of Deaner: 4 Nursing H ry at rk? 1 Yes 2 100	23e. Did tob  1 Ye  24a. Was ar autops autopriorm 1 Yes 2  th (Check only one 0 Describe ho 28f. Location (Sh. City or Town Bull Was and due to the ca	23d. Date of delive Month  23d. Date of delive Month  23d. Date of delive Month  23d. Date of delive Month  23d. Date of delive Month  24b. Were autoprior to content of the prior to content of the p	Approximate Interval Between Onset and Death  Perry Day Year  the cause of death?  bably 4 Inknov  opsy findings availab  ompletion of cause of  2 No  Ify)  al Route Number,  alstated. Assistated. Assistated. Assistated. The state of the cause (s)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 506 04 Burnie Arundel Anne If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2□ F Months 216-74-9901 Yrs 47 Director Sep 19,1959 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Anne Arundel Glen Burnie MD 1 ☐ Yes 2X No Director 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or 3 must be n USA 506 Joy Circle 21061 Items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 1 X Never Married 2 ☐ Married o. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: þ White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed r than "natur the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Parts Salesperson 12 Ith and Mental Hygier 27 Is marked other the traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eleanor Elizabeth Lange Onas D Jones ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: If Item 27 Is m any Injury or other traum once. 715 Mayo Road, Glen Burnie, Maryland 21061 Kathy Wahlhaupter/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 20, 1K Burial 2 □ Cremation 3 □ Removal from State Crestlawn Cemetery Marriottsville,MD 2007 4 Donation 5 Other (Specify) 21. Signatura Functal Service Licensee 22. Name and Address of Facility Barranco & Sons, 495 Gov. Ritchie P.A. Severna Park Funeral H Hwy, Severna Park, MD 21146 Hwy, 1 comes Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** on - Smell cell /Medical Due to (or a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner physician and the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Sg attending IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Year 4□Pregnant at time of death 5 Other (specify) by the a 9□ Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 es 2 □ No 3 ☐ Probably 4 ☐ Unknown as been s Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate ha 2 No 1⊟ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Presidence 6 □Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suícide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🛮 🚺 🚾 tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only

P.O. Box 68760. Division or Vital Records, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29d. Date signed (Month, Day, Year) MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

305

1050ital Dr

Glen Burne

Karl Kasamon

State Registrar 31. Date filed (Month, Day, AUG 1 7 2007 32. Redistrar's Signature

			State of Maryland / Department of Health and Mental Hygiene
			1- State Registrar Certificate of Death Reg. No. 2007 28   99
	Physici	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day, Year 435 PM
	/Medic		4a. Facility Name (If not institution, give street and number).  4b. City, Town, or Location of Death  4c. County of Death
	Examir	ier	HOLY CLOSS HOSPITAL SILVER SPRING, M. MONTGORERY
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year III Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
.4.0	Director		518-70-2955 517 VIS. 07-21-1950 WKShington, UC
	and w		Usual Residence of Decedent  10a. State 10b. County , 10c. City, Town or Location 10d. Inside City Limits
	Maryl f sho	jo	MD MONTGOMERY SILVER SORING
	r 28a	irec	10e. Street and Number 10g. Citizen of What Country?
	th with	al D	13/6 FENWICK LAWE" 20910-3501 USA
	r dea	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Right Status)  14. Race - American Indian, Black, White, etc.
36	s afte ", or if	by Fi	1 □ Never Married 2 □ Married 1 □ Yes 2 No   1 □ Yes 2 No   Specify: Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify
215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must <u>be notified at</u>	ed t	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
215	within 72 iene. than "na he Medi	plet	(Specify only highest grade completed)  (Give kind of work done during most of working life DO NOT use retired)  (Give kind of work done during most of working life DO NOT use retired)
21	filed withir Hygiene. other than ent, the M	Completed	12 BUS DRIVER GOVERNMEN!
pu	be fill tal H od oth	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maigen Surname)
Maryland	2 should be filed within and Mental Hygiene. is marked other than sumatic event, the Me	<u>م</u>	19a Informant's Name/Relationship (Type Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ma	nd 2 s Ith an 27 is i		DAVID JONES JR-BROTHER 6008 SELINER LANE CLINTON Md 20735
ē,	s 1 and 2 of Health item 27 i		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
Ē	Pages nent of I ant: If ite ury or o		Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensed  22. Name and Address of Facility
111	<u>v</u> ∪ = e o		BIANCH 814 Upskue st NE WAShinten, DC 20011
			23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)
	Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest resulting in death) Lest
	B #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last
8760,	icate be executed physician and the burial-transit		Due to (or as a consequence of):
687	ficate phys	edical	d.
Box	death certifi e attending id for use as	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 23d. Date of delivery
	death	by Physician/Me	in the past 12 months?  1 ☐ Yes 2 ☐ No  4 ☐ Prenant at time of death 5 ☐ Other (specify)  Month Day Year
P.0	at the I by th stache	Phys	9 Li Onkriown
Š,	requires that the een signed by th nould be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 (Dronknown
Ö	requ been should	eted	
Records,	The law ate has b	Completed	24a. Was an author prior med? 24b. Were autopsy findings available prior completion of cause of death.
	an: T tificate or, pa		25. Was case referred to medical 26. Place of Death (Check only one)
or Vital	yslck is cer direct	To Be	examiner?  1   Yes   20   No
0 0	ng Pl	nc.	27. Man Death 28a. Date of Injury 28b. Time of Injury 4t 28d. Describe how injury occurred Work?
sio	Attending Physician: r death. ector: After this certifics by the funeral director, I	cati	2 Accident investigation M 1 Yes 2 No
Division	I or At after o Direc	Certification:	3 Suicide of Could not be determined determined determined 4 Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
_	Hospital or 44 hours afte Funeral Dir tely filled in	a C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
		Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
	(2)		( Will 8 pm x ; corkang NO D 6 33 90 0/16/01
	De		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Elonde TATRANG 1500 Forest Chen Rd. 55. Md. 20910
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature
	Registi	ar	AUG 1 7 2007 Gener H. Speck

State of Maryland / Department of Health and Mental Hygien 2007 28200 1 - For Stata Registrar Certificate of Death 2 Date of Death **Physician** 440 2001 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner ISBURY If Under 24 Hrs. Wicemico If Under 1 Year 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 1 F 217-28-4655 Usual Residence of Decedent Director Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or items 23a or 28a-f show the Modical Examinar must be notified at 1 Pres 2 No Be Completed by Funeral Director Sburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Hospital Road 1801 Head Was Decedent Ever Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩idowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nt of Health and Mental Hygiene.
If Item 27 is marked other then or other traumatic event, the Market or other traumatic event, the Market or other traumatic event, the Market or other traumatic event, the Market or other traumatic event, the Market or other traumatic event, the Market or other traumatic event, the Market or other traumatic events. Elementary/Secondary (0-12) College (1-4or 5+) HomeMaker OWN Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Tubman Jane Conawai 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of commetery, cramatory or other place)

20b. Place of Disposition (Name of commetery, cramatory or other place)

20c. Location - City or Town, State Shirlene Waller MD, 2/2/5 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit Page
Department of
Importent: If
any injury or
once. 8/18/07 East NEW Market, MD. 4 ☐ Donation 5 ☐ Other (Specify) Thompson town Cometery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Heme, P. A. Henry Funeral elle 23a. Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury ue to (or as a consequence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Medical Certification; To Be Completed by Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4□Pregnant at time of death 5 Other (specify) been signed by the a 1 ☐ Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nuknown 24a. Was an autopsy performed 24b. Were autopsy lindings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending within 24 hours after death.

To the Funerel Director: At completely filled in by the fu М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatur 4005686 men 20 Alishury, MI 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) Doer's Head Hospital Center Po. 31. Date filed (Month, Day, Year) ar's Signature 32. Regi State Registrar

State of Maryland / Department of Health and Mental Hygiene Tracey A. Johnson 1- For State Certificate of Death Reg. No Registrar 3. Time of Death 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day August 6, 2007 Year 1401 hrs ব Examiner Tracey A. Johnson 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Cheverly Prince George's Hospital Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Link) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Min Months Hours Country) Director 214-92-7831 1 M 2 X F May 29 42 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 28a-f show DC. 23a or 28a-f shov notified at once. Washington Director 10g. Citizen of What Country 10f, Zip Code 10e. Street and Number 2117 I Street #7 20002 USA 14. Race - American Indian, Black Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces : U.S. Funeral 11 Marital Status unc. or items must be 1 X Never Married Married African Yes Yes, Give Yes Yes 2 X No specify. Specify: American "natural", Examiner Widowed Divorced 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 72 the Medical Mental Hygiene. marked other than 5-0036 within. 12 years Porter Privato 18.Mother's Name (First, Middle, Maiden Su unk. 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filed 2121 Be Clarence Johnson Clareb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) باطري and 27 is N N 20002 City or Town, State Washington  $\mathbf{m}$ James Henson-Fiance! nt of Heakh a nt: If item 27 other traum 20a. Method of Disposition 20b. Place of Disp timore, crematory or other place) Wash. D.C. 20019 Removal from State 1 X Burial 2 Cremation 3 Baltimo
permit Pages
Department o
Important: I Fort Lincoln Cemetery 9-17-07 Brentwood. Other Specify Donation. 22. Name and Address of Facility 21. Signature of Foneral Stewart F.H. 4001 Benn. Rd. Wash.D.C. Approximate Interval that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart rt I. Enter the disease, or complications Physician Between Onset and Hure. List only one cause on each line. Death **fledical** a. Multiple Injuries Immediate Cause (Final disease .xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, . Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit hysician/Medical  $\bar{x}$  AMENDED 5,7-10g-17, 19a-20c per fh g872 10-12-07 vt UNPENDED physician the burial requires that the death certificate be Box 68760 23d Date of delivery 23c. If yes, outcome of pregnancy IE EEMALE 23b. Was decedent pregnant in the Month Dav Year Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 亩 Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ð Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy certificate has performed' 1 🗸 Yes Νo Yes 2 26 Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other, Inpatient 2 V ER/Outpatient 3 Residence 6 DOA Nursing Home 5 this 1 Yes 2 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27. Manner of Death Certification: Subject struck by truck Aug 6, 2007 1142 hrs 1 Yes 2 V No 1 Division Natura! Pending death. Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 17th Street & Benning Road, N.E., Washington , DC determined (Specify) Major Road / Highway within 24 hours a To the Funeral 1 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 1 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie August 7, 2007 O.C.M.E. 30. Name and a ress of person who ompleted cause of death (Item 23a) Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Jack Titus MD. 31. Date filed (Month, Day, Year 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 007 28202 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician August 18, 2007 Ruth Cuff Kemp 4:30 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Potomac Valley Nursing Home Rockville | ROCKVILLE | | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2 XF Yrs. Director April 12, 1922 Maryland 84 218-12-0514 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai, or items 23s or 28s-f show Examinar must be notified at 1 Yes 2 No Directo Maryland Montgomery Brookeville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or itema 23a amp injury or other traumetic event, the Mudical Exam. and must once. 20833 3021 Holiday Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 5 3 Widowed 4 Divorced White 15 Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Comp Elementary/Secondary (0-12) College (1-4or 5+) **Electrical** Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 John Cuff Alice McGregor 19a. Informant's Name/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Kemp, son 15929 Meadow Walk Road, Woodbine, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Zva. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Dortation 5 □ Other (Specify) Woodside Cemetery 8/22/2007 Brinklow, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Molesworth-Williams PA, Funeral Him 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Physician 1000 resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetat death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Tyes 2 No certificate 1 Yes the Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: Wursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No. 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Seath 28b. Time of 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 240 ratta slavel 31. Date filed (Month, Day, Year) egistrar's Signature State 21 AUG Registrar

		1 - For State Registrar	State	of Marylan	d / Depa	artment of rtificate o	Health a f Death		gien <b>2 () (</b> Reg. No.	7 28203
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		Montgomery Gene	eral Hospit	al			01ney			tgomery
Funeral Director		5. Social Security Number 453-70-9221	6. Sex 1⊠M 2□F	7. Age (In yrs. 65	last birthday) Yrs.	If Under 1 Ye Months Day		4 Hrs. 8. Date of Birt (Month, Date July 18,	/, Year)	Birthplace (State or Foreign Country)  Texas
		Usual Residence of Decedent		140.00	-					10d. Inside City Limits
show	'n	10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1 ☐ Yes 2 ☑ No
the N 28a-f	Directo	Maryland Montgo	omery			10f. Zip Cod	Ashton		10g. Citizen of V	/hat Country?
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death	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U	.S. 13.			in? (Specify Yes or No- Puerto Rican, etc.)	14. Race Blac	e - American Indian, k, White, etc.
parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.  Department of Health and Mental Hygiena.  Department of Health and Mental Hygiena.  Pages of 188-1 show any injury or other traumatic evant, the Medical Evanth or must be notified at once.	by Fu	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced		2 ☑ No ive	i i	1□Yes 2⊠ N			Specify	White
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and 2 alth a 27 is er tra		Ann Key - Wife	9		1794	47 Pond Re	oad, Asht	on, Maryland		
of He of He item	V 35	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from		Place of Dispo cemetery, crea	osition (Name of matory or other p	olace)	Date	20c. Location -	City or Town, State
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ast.		Michael Brian W		O., 11801 Registrar's Sign		Philip D	rive, Oln	ey, Maryland	20832	
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		For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of rtificate o	Health and Death	Mental Hy	giene <b>z ()</b> ( Reg. No.	07	28204
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/Medic			dbergh Love	2	1		August	11, 200	)7	6:15 P M
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pu ,		Usual Residence of Decedent	10.0	-			7410 13	, 2,2,		
arylar how	5	10a. State 10b. County		ity, Town or Lo					1	10d. Inside City Limits 1√2 Yes 2 □ No
28a-1	Director	Maryland Prince  10e. Street and Number	George's	Ade1ph	1			10g. Citizen of W	that Cour	
To ag	<u>a</u>	1801 Metzerott R	oad		10f. Zip Code	783		United		
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Department of Heelih and Mental Hygiene. importent: if item 27 ie marked other then eny injury or other treumatic event, the Magnee.		Robin Love-Jorda  20a. Method of Disposition  1 Suburial 2 Cremation 3 C	Removal from State	Place of Dispo cemetery, crei	osition (Name of matory or other p		Date	20c. Location -	n D City or To	C 20017 own, State
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		- Apple	8			529		August	16,	2007
SC		30. Name and address of person who				204				
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Registr		AUG 1 7 2007 &								

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiena 28205 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 18, 2007 **Physician** Dorothy I. Launt 7:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ft. Washington Prince George's 12700 Livingston Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Nonths Days Hours Min. (Month, Day, Year)

Lec. 12, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX Pennsylvania Director 83 049-16-7774 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ehow ir then "naturel", or itema 23a or 28e-f ehov the Modical Examinar must be notified at 1 Yes XXXVo Maryland Prince George's Ft. Washington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12700 Livingston Road 20744 USA naturel', or itema 23a Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ NoWWⅢ If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. , White 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygier important: if item 27 ia marked other then any injury or other traumatic event, ILM ODG. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Florence W. Kuhn Cooney 2 George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12700 Livingston Road Ft. Washington, Maryland Robert Launt Jr. / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Hemoval from State St. Paul's Cemetery 08/20/2007 4 ☐ Donation 5 ☐ Other (Specify) Loysville R.D., Penna. 21. Signatur Funeral Service Licensee 22. Name and Address of FacilityGeorge P. Kalas Funeral Home ales 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death CORONARY ARTERY DISEASE **Physician** /Medical Due to (or as a consequence of): Examiner END STAGE RENAL DISEASE (DIALYSIS) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this confined to the Funeral Director: After this confined to the Funeral Director. use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Certification; To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery ate has been signed by the atten page 2 should be detached for u 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 🖄 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 1 No 1 Yes 2 No 1 Yes after death.

Director: After this certific
I in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 12Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 53782 August 20, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingston Road # 101 Ft. Washington, Maryland 20744 Suresh Verghese, MD 32. Registrar's Signature State AUG"2"0"2007 Registrar

	·		ertificate of	Death	Reg.	N2007	28206				
Physicia		1. Decedent's Name <i>(First, Middle, Last)</i> Kathy Jo Letwinsky Moriarty			Date of Death Month	Day Year	3. Time of Death				
/Medic Examin		4a. Facility Name (If not institution, give street and number) Baltimore Washington Hospital Center		or Location of Death Burnie		4c. County of Death	1				
Funeral Director		5. Social Security Number 213-88-4896	Months Davis		Date of Birth (Month, Day, 7) 0/3/196	(ear) 9. Birth Cot Ma	nplace (State or Foreigr intry) aryland				
/land ow		Usual Residence of Decedent  10a. State 10b. County 10c. Cify, Town or	Location				10d. Inside City Limits				
e Man Ba-f sh tiffed a	ctor	MD Anne Arundel Odenton	1				1 □Yes 2X No				
th with the 23a or 24 ust be no	Funeral Director	10e. Street and Number 1018 Summer Hill Dr.	10f. Zip Code	21113	10g	0g. Citizen of What Country? USA					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important: If then Z7 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medic 1 Ex. miner must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 223No	Hispanic Origin? (Specifican, Mexican, Puerto Rid	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: White					
n 72 hc "natu	letec	(Specify only highest grade completed) (G	cedent's Usual Occu ive kind of work done	pation during most of working ed)	16	b. Kind of Business/I	ndustry				
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uld be file Mental Hy Irked othe	To Be (	17. Father's Name ( <i>First, Middle, Last</i> )  Carl A. Letwinsky		18. Mother's Name (F Barbara J							
and 2 sho ealth and I n 27 Is me		Carl A. Letwinsky Father 1018	Summer H			City or Town, State, Z MD 21113	ip Code)				
ages 1 nt of H t: If Iter / or oth		T Duliai 2xxere liation 3 Line lioval from State	sposition (Name of crematory or other pla	1		c. Location - City or					
mit. P partme portan y injun		4 □ Dof lation 5 □ Other (Specify) Metro Cr 21. Signature of Fun-ral Service Licensee		08/17/ ess of FacilityHarde		altimore, eral Home					
og ar ar og				y Ave. Anna							
Physician	8 1	23a. art I. Enter the divease, or complications that caused the death. Do not hook, or learn falure. List only one cause on each line.  Immediate Cause (fine)  I disease or condition		ng, such as cardiac or re	espiratory arrest	i,	Approximate Interval Between Onset and Death				
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Physi or this o	2	1  Yes 2 No Hospital: 1 Ininpatient 2  ER/Outpat  27. Manner of Death 28a. Date of Injury 28b. Time	TIGHT OF BOX		5 Residence	ce 6 ☐Other (Speciniury occurred	rify)				
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i dite	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f.	Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,				
the Hospital hin 24 hours a the Funeral mpletely filled	Medical	29a. Certifier (Check only one)  1 ★Certifying Physician: To the best of my knowledge, de control on the basis of examination and/or and manner stated.	eath occurred at the t r investigation, in my	ime, date and place, and opinion, death occurred	d due to the caus at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)				
To T CO	2	29b. Signature and title of certifier  WY	29c. Licens	3726		Date signed (Month)	n, Day, Year)				
Land		30. Name and address of person who completed cause of death (Item 23a) (Typ		50 HUS		المركب الم	21/20				
Sta		31. Date filed (Month, Day, Year)  AUG 1 7 2007  AUG 1 7 2007	hout .	UNLEGY	021369	1/ = 6)/	10912 G				
Registr		AUG 1 7 2007	March 1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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k g	Physicia		1. Decedent's Name (First, Mid Edith A. Mato				001	inoute or	Douin		2. Date of De Month August		2007 Par 7	3. 2m8 2a0 11:00 P ^M
	/Medic Examin	_	4a. Facility Name (If not institute					4b. City, Town, o					ounty of Death	11.00 1
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hydiene. Department of Health and Mertal Hydiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show important: If Item 27 is marked other than "autorial" or any Injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	Maryland Anne Arundel Edgewater											1 □ Yes 2 □ <b>X</b> No
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	leath v	Maryland   Anne Arundel   Edgewater   10e. Street and Number   3610   Solomons Island   Road   21037   11. Marital Status   12. Was Decedent Ever in U.S. Armed Forces?   1.   Never Married   2.   Married   1.   Never Married   2.   Married   1.   Never Married   2.   Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.   Never Married   3.										SA I. Race - Americ	an Indian,	
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	To the Hospital or within 24 hours afte To the Funeral Di completely filled in	Medical	29a. Certifier 1 Certification (Check only one)	al Examiner: O	To the best n the basis o d manner st	of examinat	wledge, deat tion and/or in	th occurred at the to rivestigation, in my	ime, date a opinion, de	ind place, a	and due to the ed at the time	e cause(s) a e, date and p	and manner as s place, and due t	stated. to the cause(s)
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	Bur			ressey	200	>		DOZ	-	*			16-0	
,	り ^下		30. Name and address of pers	er m	d cause of c	death (Item 3 1 6 9	23a) (Type, BRAV	Print)	7 #	101	ED OF	WATE	R, MD	21037
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State of Maryland / Department of Health and Mental Hygiene

An	nended	itė	m State #1, per ph	ysician,8/21	/07,BA	Certificate of	Death ^{WCHD}		Reg. No.	007	00000
u.	Physici	100	1. Decedent's Name (First, Middle,	Last)				Date of Dea     Month	ath Day	UUI	321180500118
	/Medic		Trances Mall	<del>eti</del> Fran	ces Mal	leti		8	17	2007	14:03 M
	Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	r Location of Death		4c. Co	unty of Death	
			University of Ma	ingland Med	ical Ct		more				
	Funeral		Social Security Number 6	4 🗆 44 087 🗉	(In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	v. Year)	9. Birthp	nlace (State or Foreign
١.	Director		215-26-5525	7 TOW 220 7	5 Yr	S.		7/12/	1932		MD
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	er de	nue	11. Marital Status	12. Was Decedent Ev Armed Forces?		<ol> <li>Was Decedent of H If Yes, specify Cub</li> </ol>	lispanic Origin? (Spe an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	. 14.	Race - Americ Black, White,	
36	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show idical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:	)	1 □ Yes 2 □XNo	Specify:		St	pecify: Wh	ite
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$\leq$	should be and Menta s marked umatic ev	ို	19a. Informant's Name/Relationship	<u> </u>	19h I	Mailing Address (Street				own State 7ii	Code)
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	of Heal		Steven Michael 20a. Method of Disposition	nall/ Son	20b. Place of D	Disposition (Name of		Date	20c. Local	tion - City or Te	own. State
ŏ			1 Surial 2 ☐ Cremation 3		cemetery	crematory or other pla	i i				, 4
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Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of June 1. Service Li	censee 2	2	22. Name and Addre		urbage			
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Вох	attendin	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1 ☐ Live birth 2	Fetal death	3 ☐ Ectopic pregnanc	у		230	<ul> <li>Date of deliv</li> <li>Month</li> </ul>	ery Day Year
0	The law requires that the death ce ate has been signed by the attendi bage 2 should be detached for use	Physician/P	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime of death	5 ☐ Other (specify) _					,
<u>С</u>	that the	P.	Part II. Other significant condition	e contributing to death but	not regulting in	the underlying cause give	on in Part I	23e Did t	obacco use	contribute to t	he cause of death?
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ec	law las b	lg l						24a. Was auto	psy	prior to co	opsy findings available ompletion of cause of
E =		Completed							ormed? 2 ⊠ No	death? 1 ☐ Yes	2 🗆 No
Vital	Physician: this certific ral director,	Be (	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only o	one)		
or/	Physic this c al dire	2	1 ☐ Yes 2 ☑ 1√10	Hospital: 1 patien		Datient 3 DOA	ner: 4 Nursing Ho	me 5 ☐ Resi	dence 6 [	☐Other (Speci	fy)
n			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	<i>Year)</i> 28b. Ti	me of 28c. Inju jury Wo	ry at rk?	28d. Describe	how injury o	occurred	
Sio	Attending r death. ector: After y the fune	atic	2 ☐ Accident investiga	t he			Yes 2□No				
Division	- 0 - C	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At home, fari . <i>(Specify)</i>	m, street, factory, office			Street and i wn, State)	Number or Rui	al Route Number,
Ω	ital c irs af iral D			4							
	e Hospital 24 hours a e Funeral letely filled	ica	(Check only 2 Medical E	Physician: To the best of xaminer: On the basis of	examination and						
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	Medical	one)	and manner stat	ed.	29c. Licen	se number	1	20d Date	signed (Month	Day Yearl
	5 Mi j		29b. Signature and title of certifier			25C. Licen	1111001				
•			1	B		De-	1001		Augi	ust 17	200+
BF	15		30. Name and address of person w	ho completed cause of de	ath (Item 23a) (T	ype, Print)	2 11		J		
יע			21 Data Fled (Month Day Year)	22 S	r's Signature	species St.	, saltin	rone, r	ND	2120	1
	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 1	2007 Segistra	o Gigilalde	Sparle					
	riegist	1	HOU ~ I	1							

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar  Decedent's Name (First, Middle, La.			ertificate of			Reg. No.?	07	28209
Physi /Me	ician dical	1	JOHN GILBERT	MORGAN				Month	8, 200	Year	12:00 p ^M
Exam			a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Death		4c. Cour	ty of Death	
	SQUARE OF STREET		3764 Post Office  Social Security Number 6.8		e (In yrs. last birthday	Eden  If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	Wico		place (State or Foreign
Funera Directo				<b>⊠</b> M 2□F	76 Yrs.	Months Days	Hours Min.	Dec. 3,	y, Year)	Cour	yland
laryland show	2	1	0a. State 10b. County		10c. City, Town or L	ocation					0d. Inside City Limits
the M 28a-f notifie	Director	5	MD Wicomico  Oe. Street and Number	)	Eden	10f. Zip Code			10g. Citizen o	f What Cou	
a or		5	3742 Post Office	Poad		21822			· ·	SA	,
death ms 2	Fineral	1	1. Marital Status	12. Was Decedent B	Ever in U.S. 13	. Was Decedent of H	lispanic Origin? (S	pecify Yes or No		ace - Americ	
d within 72 hours after death with the Maryland glene. r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	2	2	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 N Yes 2 N If Yes, Give N Year or Dates:	rean	1 ☐ Yes 2 ☑ No	Specify:	o Rican, etc.)	Spec	lack, White, cify: wh:	
n 72 hou "nature ledical E	Completed	Daleico	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dec (Giv life.	edent's Usual Occup e kind of work done DO NOT use retired	oation during most of wor d)	king	16b. Kind of	Business/In	dustry
T T +	į	5	Elementary/Secondary (0-12)	College (1-4or 5	+)	rpenter	•		Boat B	uildir	na
ent,	B G		7. Father's Name (First, Middle, Last	)			18. Mother's Nan				
	ļ	2	Herbert Morgan				Maggie '	Taylor			
and s m			19a. Informant's Name/Relationship (		1	ling Address (Street					Code)
1 an Heal		-	Vicki Evans (dauc	ıhter)		Post Off		Eden, M	20c. Location		own State
es of f		1	1 Burial 2 Cremation 3	Removal from State	1	position (Name of ematory or other place	i			Ť	
# E E E	ouce.		4 Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice		-	ft Registry 22. Name and Addre	ss of Facility Sa	0/2007 alisbury	, MD 2	1804	
90 = 8	a	1	23a. Part1. Enter the disease, or com shock, or heart failure. List only	1 Dear		olloway F	uneral Ho	ome, P.A	., 501	Snow	Hill Rd.  Approximate Interval Between
Physicia / Medica Examine be executed be believed as the purial-transit	Fxaminer	Evalilliei	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, f any, leading to immediate cause. Enter Understand that initiated events resulting in death) Last	b	a consequence of): a consequence of):	Cercire	ma				18 mont
the death cer by the attendin ached for use	Physician/Medical		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc	у			Date of deliv	ery Day Year
ires that signed b	2	ٔ ج	Part II. Other significant conditions	contributing to death be	at not resulting in the	$\wedge$	ren in Part I.	23e. Did t		3 .	he cause of death? bably 4 □Unknov
w requir been si should b	pto		14 100	-			17 0001	24a. Was	an 24	/0	
	Completed	- L	Vascula	Λ.	re e			auto	osy ormed? 2 No	prior to co death? 1  Yes	opsy findings availat impletion of cause o 2 \( \text{No} \)
slcian; Th certificate rector, pag	å	۵	25. Was case referred to medical examiner?  1 ☐ Yes 2 ♣No	Hospital:		ont 317 DOA Oth		ath (Check only c			daughter
Attending Physician; r death. ector: After this certific by the funeral director.	on. To	- 1	27. Manner o Death Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry 28b. Time	of 28c. Injui	ry at rk?	fome 5 ☐ Resi			home
in Dir	Certification.	e III Can	2 Accident 3 Suicide 4 Homicide  investigation 6 Could not be determined	e 28e Place of inju	ury - At home, farm, s c. (Specify)		Yes 2 □ No	28f. Location (3 City or To	Street and Nu vn, State)	mber or Run	al Route Number,
Hospital 24 hours a Funeral etely filled	Pedical C	J Isal	29a. Certifier (Check only one)  Check only 2 Medical Example (Check only one)	nysician: To the best of miner: On the basis of and manner sta	examination and/or	ath occurred at the ti investigation, in my	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and date and plac	manner as se, and due t	stated. to the cause(s)
To the within 2 Fo the comple	Mer		29b. Signature and title of certifier	wild mainler ste		29c. Licens	e number		29d. Date sig	ned (Month,	Day, Year)
->-0			I Jelle	10		200	5326	2	08	-21	-07
		10	30. Name and address of person who	completed cause of d	noth (Itom 22a) (Tyro	D-1-4)					
S ET	Ш		Dr. John Whittake				4 5	.1		1051	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day :20 AM Month **Physician** line August 14 2007 /Medical 4a. Facility Name (Khot institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dorchester 114 Belvedere Avenue Cambridge If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🛣 F 6 Director 210-28-0706 18,1940 Pennsylvania Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at Dorchester MD Cambridge 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 114 Belvedere Avenue 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify: ģ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) x-ray technician health care 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Yandrofski Mary Shostak 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) husband 114 Belvedere Ave., Cambridge, MD Clarence R. Moore Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or conce. 1 MBurial 2 □ Cremation 3 □ Removal from State 8/17/07 4 Donation 5 Dother (Specify) Maryland Veterans Cem Hurlock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final small cell Physician Lini NON Caucer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Ho 24a. Was an page 2 has autopsy performed? Yes 20 No this certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manual of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation death. 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 31. Date filed (Month, Day, Year) **AUG 1** 6 2007

THANOY

29b. Signature and title of certifier

NOMAN



BYRN

MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAMPRIDGE

29d. Date signed (Month, Day, Year)

MD 21613

15-07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007

1- State Amend #3, 8-21-07, per Dr., Help al Registrar

State of Maryland / Department of Health and Mental Hygiene 2007

Help al Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 132 45 pm Month Year Physician VIRGINIA NAJDOWSK М. 2007 08 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD RUTLAND ROUND COLUMBIA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 € F Days Hours 90 Yrs. 320-10-159 Director ILLINOIS July 25,1 Usual Residence of Decedent 10a. State or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Director MD Howard Columbia the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rai', or iteme 23a or Examiner must be ? 10226 Rutland Round Road 21044 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 至 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3X Widowed 4 ☐ Divorced "natural" White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than vent, the Me Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Anthony Lutze Anna Martha Wilson permit. Pages 1 and 2 shoul Department of Health and Milmportant: If Item 27 is marteny Injury or other traumations. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis J. Pouleris/daughter 10226 Rutland Round Rd. Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 08/20/07 Beltsville, MD 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a METASTATIC COLON CANCER 6 WEEKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.O. ete hes been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Denknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician; funeral director 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29a. Certifier Medicai (Check only one) the t 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D29307 10 and address of person wh completed cause of death (Item 23a) (Type, Print) ST. PAUL PLACE BURK E312 BALT, HD 21202 301 ROSEMARK OLIVO MO 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

**AUG 2 1** 

**ORIGINAL** 

		Plea  1 - State Registrar	se Type or State	of Marylan	d / Dep	artme	nt of H		and Me			2007	
Physic /Medi		1. Decedent's Name (First, Middle Gertrude Flizat		rath			10 07 1	Journ		2. Date of De Month	ath Da		3. Time of Death
Exami		4a. Facility Name (If not institution 3200 N. Leisure Wo	give street and no	#110	10 Silver Spring						4c. County of Death  Montgomery		
Funeral Director		5. Social Security Number  098-07-2772  Usual Residence of Decedent	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 87	Yrs.	Months Days Hours Min (Month, Day,					sy, Year) Country)		
the Maryland 28a-f ehow notified at	rector	10a. State 10b. County  MD Montgon  10e. Street and Number	nery		ilver Sp	ring	ip Code				10g. Cil	tizen of What	10d. Inside City Limit 1 ☐ Yes 2 🛱 N
in 72 hours after death with the Maryland "naturel", or items 23a or 28a-f ehow wolcal Expenier mart be notified at	Funeral Director	3200 N. Leisure Wo	12. Was De Armed F	cedent Ever in U	.S. 13.	Was Dec	2090 edent of H ecify Cuba		igin? (Spec	cify Yes or No Rican, etc.)	USA		nerican Indian, nite, etc.
2 hours af laturel', or ical Exs.	by	3 X Widowed 4 ☐ Divorced	If Yes, G Year or	If Yes, Give Year or Dates:  ducation  16a. [			1 ☐ Yes 2 ☒ No Specify:  sedent's Usual Occupation we kind of work done during most of working					Specify:	White s/Industry
c * 3	Completed	(Specify only highes Elementary/Secondary (0-12) 12	College	(1-4or 5+)	life.	emake	use retired					Own Hame	
Elementary/Secondary (0-12)  12  College (1-4or 5+)  Homemaker  17. Father's Name (First, Middle, Last)  Adam Schorr  19a. Informant's Name/Relationship (Type, Print)  Martha M. Iacono / Daughter  20a. Method of Disposition  1X Burial 2 Cremation 3 Removal from State  18b. Mailing Address (Street 3200 N. Leisure 20b. Place of Disposition (Name of cemetery, crematory or other place)							Dor	othea					
1 and 2 sh Health and Bm 27 is m ther traum		19a. Informant's Name/Relations.  Martha M. Jacono  20a. Method of Disposition	hip (Type, Print) /Daughter	20b. F		l. Lei	sure W		31vd, #		lver		MD 20906
Pa ant:		1 Meurid of Disposition  1 M Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)  21. Signature of Funeral Service	pecify)	State	emetery, cre e of Hea	matory or ven C	other plac emeter	v Ai	ıa 21.	2007	Si lve	er Spring	r. MD
Departition of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the co		23a. Part1. Enter the disease, or		caused the deat	50	00 Uni	versit	y Blvc	W, Si	lver Sp	ring,	Funeral MD 2090	Home, Inc.
Physician /Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on	each line.  xacerbatio	on of co					Tospiratory a			Interval Between Onset and Death Immediate
Examiner	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bC	ardiomyope o (or as a conseq	athy								5 years
eath certificate be executed attending physician and for use as the burial-transit	Ilcal Examiner	Cause (Diseese or injury that initiated events resulting in death) Last		ypertensic o (or as a conseq									0 years
0 0	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live	utcome of pregna birth 2 Feta gnant at time of d nown	death 3	□Ectopic   □ Other (s	pregnancy					23d. Date of o	lelivery Day Year
w requires that the been signed by th should be detache	ed by PI	Part II. Other significant condition  Chronic anemi	_	death but not res	ulting in the u	inderlying	cause giv	en in Part I	I.		tobacco Yes 2		to the cause of death?  Probably 4 Unknow
The law ate has b page 2 sl	Completed by	Chronic renal	failure				-			24a. Was auto perfo	psy ormed?	prior t death	autopsy findings availab o completion of cause of ? es 2 \sum No
ician certifi ector	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2√☐ No 27. Manner of Death	Hospital: 1		ER/Outpatie			er: 4 □ Nı	ursing Hom		dence	6 □Other (Si	pecify)
ling After une	Certification:	1 X Natural 5 ☐ Pendin 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	gation not be 28e. Plac	of Injury nth, Day Year) ce of Injury - At h	28b. Time of Injury	М		yat k? Yes 2□	No		Street a	nd Number or	Rural Route Number,
To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the f		29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the	basis of examina	owledge, deat	h occure	d at the tin	ne, date ar	nd place, a	City or To	cause(s	s) and manner	as stated.
To the H within 24 To the F complete	Medical	29b. Signature and title of certifie	and ma	nner stated.	iA.	2	9c. Licens				29d. Da	ate signed (Mo	nth, Day, Year)
2_		30. Name and address of person	who completed car	use of death (Iter	n 23a) (Type,		7002	UUI			rugi	UST 20	2007

(3) by State Registrar

Samuel Maller MD, 3305 N Leisure World Blvd, Silver Spring, MD 20906
31 Date filed (Month, Day, Year)

AUG 2 1 2007

AUG 2 1 2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien

			State Registrar			Certificate of Death					.007	20213
			1. Decedent's Name (First, Middle	e, Last)					2. Date of De	eath		3. Time of Death
	Physicia			Majano					Month August	Day	Year	4:25 a M
	/Medic	- 1	Agustin 4a. Facility Name (If not institution	Ma jano			4b. City, Town, o	r Location of Dea			County of Death	4.23 a
	Examin	er	Soll Pine	_ / [	01#	101	- /		Bull A.	n	nonto.	omerk
			5. Social Security Number		(In yrs. last		If Under 1 Year	If Under 24 Hr				place (State or Foreign
	Funeral	ĺ	, , , , , ,	10.36x 7.Age		Yrs.	Months Days	Hours Mir	. (Month, D	ay, Year)	Cour	ntry)
	Director		216-63-4856 Usual Residence of Decedent		45				Aug 28,	1961	l El Sa	lvador
	and *		10a. State 10b. County		10c. City, T	own or Loc	eation					0d. Inside City Limits
	sho sho sd at	<u> </u>										1 ∐Yes 2 No
	Ba-f	Sc.	MD Montgo	mery		Silve	er Spring	J				
	or 2	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cour	ntry?
	th w	<u>a</u>	8611 Piney Bran	ch Road #101			20901			El Sa	alvador	
	72 hours after death with the Maryland "natural" or items 23a or 28a-f show kilcal Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. V	Vas Decedent of H Yes, specify Cub	lispanic Origin? ( an. Mexican, Pue	Specify Yes or Nerto Rican, etc.)	0- 1	<ol> <li>Race - Americ Black, White,</li> </ol>	
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5-0036	ral",	<u>\$</u>	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	-				American		Whit	e
2	72 h	šec	15. Deceder	t's Education st grade completed)	1	6a. Deced	ent's Usual Occup	oation	orkina	16b. Kin	nd of Business/In	dustry
2	be filed within 72 ho tral Hygiene. d other than "natu event, the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. E	kind of work done OO NOT use retired	d)	orking			
7	gien gien the	PO.	5			Van 1	Driver			Const	truction	_
◙	a filed al Hygi other /ent, t	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Na	ame (First, Middle	e, Maiden S	Surname)	
<u> </u>	ld be lental ked o ic eve	To E	Rutilio Sorto	Guevara				Felina	Ma jano			
Maryland	should I and Men marker	-	19a. Informant's Name/Relations			19b. Mailin	g Address (Street			ber, City or	Town, State, Zij	Code)
Š	id 2 Ith a 27 is trau		Folina Majana da Ca	orna /Mothon		נת נוט	D	D 3 #301		g	150 0000	
a)	1 and Health em 27 ther to		Felipa Majano de Gu 20a. Method of Disposition	ievara/rbuier	20b. Place	e of Dispos	ney Branch	1 KO90 #10.	Date		cation - City or To	
ğ	Pages 1 and 2 should b nent of Health and Ment int: If item 27 is marked iny or other traumatic e		N☐Burial 2 ☐Cremation				natory or other pla	΄ Δ110	24		as de Cond	
	t. Pag tment tant: I ijury o		4 Donation 5 Dother (5	* **	Genera		etery Mora	ezan 200		Mor	ריבו	Salvador
Baltimore,	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service	Licensee			Name and Addre		aral Home	10100000000	,124.3a1	
_	0 0 = 0 0		Joseph	1. John		500	University	Blvd West	Silver	Spring	MD 20901	
			23a. Part . Enter the disease, o shock or heart failure. List	r complications that caused tonly one cause on each lin	the death. I	Do not ente	er the mode of dyir	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ac	6	. 0	1 ***					Onset and Death
	/Medical		resulting in death)	a. Due to (or as a	nsequen	ce of):	750					6
	Examiner											
		e e	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequen	ce of):						
	uted Insit	声	cause. Enter Underlying Cause (Disease or injury									
	al-tre	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequen	ce of):				***		
09/89	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit											
δ	icate phys s the	Medical		d								
×	certif ding se as		IF FEMALE:	23c. If yes, outcome	of pregnancy	4					od Data at dalla	
9	death e atten	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at	2 🗌 Fetal de	eath 3⊑	Ectopic pregnanc	у		2	3d. Date of deliver. Month	Day Year
o	the de	Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	une or dead	II 5L	Other (specify) _					
Ţ.	hat ti d by letac	F.	Part II. Other significant conditi	one contributing to death by	it not resultin	o in the ur	derlying cause giv	van in Part I	23e Did	tohacco us	se contribute to t	he cause of death?
က်	requires that een signed b	þ	Tarrii. Other organization contain	one continuating to doubt be	it frot receitin	ig in the di	donying oddoo giv	on in rare.			No 3 □ Prot	1.
0	pluoi	ted		***						) 163 ZL		Sabiy 4 AUTRIOWIT
ecord	law as b	Completed							24a. Wa	s an opsy	24b. Were auto	ppsy findings available impletion of cause of
ř	sician: The law certificate has t irector, page 2 s	E							per 1□ Yes	formed? 2 X No	death? 1 ☐ Yes	•
	an; tiffica tor, p	0	25. Was case referred to medica	ıl				26. Place of D	eath (Check only			
	Physician: this certificanal director,	To B	examiner? 1 X Yes 2  No	Hospital:	nt 2∏ER	/Outpatien	t 3□ DOA Oth	or.	Home 5 Res		i ∏Other (Speci	fv)
Ö	y Ph		27. Manner of Death	28a. Date of Injur	y 28	Bb. Time of	28c. Injui		28d. Describe			0/ 1/
0	tun fun	ţ	1 ☐ Natural 5 ☐ Pendir 2 ☐ Accident investi	gation Aug 18		Injury うらをご	M 1 🗆	rk? Yes 2 <b>X</b> No	hans	י לינירו	-541-1	nflicked
UIVISION	Atter dea octor	fica	3⊠Suicide 6 ☐ Could	not be 28e. Flace of inju	ry - At home		et, factory, office		28f. Location	(Street and	d Number or Run	al Route Number,
	after Dire	Certification:	4 ☐ Homicide determ	building, etc	:. (Specify)	NO=	ny		City or To	own, State)	Sell Pla	al Route Number, OR
_	To the Hospital or Attending Physician; within 24 hours after deal; To the Funeral Director; After this certific completely filled in by the funeral director,		29a. Certifier 1 ☐ Certifyi	ng Physician: To the best o				me, date and pla			~	
	24 h	dice	(Check only 2 Medical one)	Examiner: On the basis of and manner sta	examination	and/or inv	estigation, in my	opinion, death oc	curred at the time	e, date and	place, and due t	o the cause(s)
	of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the	Medical	29b. Signature and title of certifie	1			29c. Licens	se number		29d. Date	e signed (Month,	Day, Year)
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	12		30. Name and address of person	MYCKU!	myD	1110	000	7/20	00	10	7	200/
(G)	12		30. Name and address of person	who completed cause of de	eath (Item 23	ia) (Type, I	rint) 2   0	mean	cax 1-a	1K	ント	
				ECHER MO	r's Signature	5	Silve	er zpr	ing or	10.	2090.	_
	Sta Registr		31. Date filed (Month, Day, Year,		irs Signature	V A	and a	-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 7.8 per winf 1880 / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) cNair 1:10 AM 200 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Blue Ridge Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 ☐ M 2 🖾 F -62 Yrs. 260-68-4989 Georgia Nov Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☑ Yes 2 ☐ No Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20737 USA 6616 Hillwood Drive 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married **Black** 1 ☐ Yes 2X No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private 12th Cosmoetologist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henley Johnnie Baker George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5415 76th Avenue Hyattsville, Maryland 20784 19a. Informant's Name/Relationship (Type, Print) Cheryl McNair/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □Burial 2 □ Cremation 3 □ Removal from State Resurrection Cemetery 8/18/2007 Clinton, Maryland Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 ☐ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DQA Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Magner of Death 28b. Time of 28d. Describe how injury occurred 1 Natura. 2 Accident 5 Pending investigation 1 🗌 Yes 2 No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

**Physician** /Medical **Examiner** Examiner The law requires that the death cartificate be executed burial-transit Box 68760 Physician/Medical the as esn for Division of Vital Records, P.O. detached by Completed has To the Hospitel or Attending Physicien: filled in by the funeral diractor, Be 2 this After Certification: death. within 24 hours after deat To the Funarel Director: Medical

**Physician** 

/Medical

Examiner

Funeral

Director

28e-f ehow

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or Items 23a

permit. Pagas 1 and 2 should ba filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Item

Baltimore, Maryland 21215-0036

Director

Funeral

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other traumatic event, the Medical Examinar must be notified at

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injury

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DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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7 2007

pleted caese of death (Item 23a) (Type

32. Registrar's Signature

	·	For State Registrar	State of Maryla		ertificate of	Death	id Melli	Re	g. N 200	7 28215	
Physicia /Medic		Decedent's Name (First, Middle, La  Maude Be	st) ethea Mann:	ing			I N	ate of Deatl lonth <b>gust</b>	Day Y	3. Time of Death <b>10:50P</b> ^M	
Examin		4a. Facility Name (If not institution, give			4b. City, Town, o		Death		4c. County of	Death	
Funeral		Washington Adv 5. Social Security Number 6.5		pital rs. last birtho		oma Pa		ate of Birth		Omery  Birthplace (State or Foreign	
Director		579-50-3062	1□ M 2xF 85	Yrs	Months Dave	Hours	Min. (/	ate of Birth Nonth, Day, 8–16-	Year) -21 [	Birthplace (State or Foreign Country) illon, S.C.	
land ow		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town o	r Location	·				10d. Inside City Limits	
e Mary la-f sho tifled a	ctor	S.C. Dillor	า	Di	llon					1 <b>⅓</b> es 2 □ No	
leath with the Marylar ns 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Number 305 South 9t	h Ave.		10f. Zip Code <b>295</b> .	36		10	Og. Citizen of Wh	*	
death	nera	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S.			res or No-	14. Race -	American Indian,		
should be filed within 72 hours after death with the Marylanc nd Mental Hygiene. • marked other than "natural", or Items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	er in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 ▼No Specify:						White, etc. Black	
72 hc	eted	15. Decedent's E (Specify only highest gro	ducation ade completed)	16a. De	ecedent's Usual Occup live kind of work done le. DO NOT use retired	ation during most o	of working	II.	16b. Kind of Busin	ness/Industry	
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filed Hygie	ပိ	17. Father's Name (First, Middle, Last				18. Mother's	s Name (Firs	t, Middle, N	faiden Surname)	Denoois	
ild be lental ked c	To B	Robert McClo	oud				na Pr		,		
shou and M s mar umat	-	19a. Informant's Name/Relationship	(Type. Print)	19b. M	ailing Address (Street	and Number	or Rural Rot	ıte Number,	City or Town, St	ate, Zip Code)	
and 2 ealth a n 27 is er trau		Ronald Bethea			14- 15th		Tako				
permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items any Injury or other traumatic event, the Medical Examiner mione.		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Themoval nom State   🛖		sposition (Name of crematory or other place lale cem.	ce) {	Date <b>3/18/</b>			ty or Town, State  Cty, S.C.	
permit. Departr Imports any Inju		21. Signature of Funeral Service Lice	Hacket A		22. Name and Addre Hackett 814- Uj	ss of Facility Es Fu	nera	l Cha	apel, I	nc.	
Physician /Medical Examiner		23a. 14.1. Enter the disease, or comphock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. TAPH C Due to (or as a cons  b. Due to (or as a cons Due to (or as a cons	LO (equence of):	enter the mode of dyin	ng, such as ca	erdiac or res	piratory arre	est, E PSIS	Approximate Interval Between Onset and Death	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  The the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Aedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  CARDIAC ARRHYTHMIA									
w requires that the death certifi been signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fo 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death	3 □Ectopic pregnanc 5 □ Other (specify) _	/			23d. Date of Month		
quires that n signed b ild be deta	by	Part II. Other significant conditions	contributing to death but not r	esulting in th	e underlying cause giv	en in Part I.				ute to the cause of death?	
siclan: The law rev certificate has bee irector, page 2 shou	Completed						_	24a. Was ar autops perforn I□ Yes 2	y prid ned? dea	ere autopsy findings available or to completion of cause of ath?  ] Yes 2 □ No	
ertifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place o	f Death (Ch				
shysic this c	은	1 Yes 2 No	43		tient 3 DOA Oth	4 L Nurs			nce 6 Other		
ath. or: After ne funer	ation:	27. Manner of Death  1		28b. Tim Inju	ry Wor	yat k? Yes 2∐No		Describe ho	w injury occurred		
al or Atta	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		home, farm, ecify)	street, factory, office			ocation (Sti City or Town		or Rural Route Number,	
o the Hospital or Attending Physician; ithin 24 hours after death. o the Funeral Director; After this certific typletely filled in by the funeral director,	edical C	29a. Certifier (Check only one) Condition    **Tertifying Planck**    **Description    **De	hysician: To the best of my k miner: On the basis of exam and manner stated.	nowledge, d ination and/o	eath occurred at the tier investigation, in my	me, date and opinion, death	place, and on occurred at	lue to the ca	ause(s) and manr ate and place, an	ner as stated. d due to the cause(s)	
T with the	Me	29b. Signature and title of certifier	ndla	10.	29c. Licens		0	29	9d. Date signed (	Month, Day, Year)	
(6)		> Chamebsell	la Day or			52	855	5 0	18-1	3-07	
EX.		30. Name and address of person who Chandrasekha:	r Korapati,	M.D.	16300 Ga]	lant	Fox	Lane,	Bowie	, Md 20715	
Sta Registr		31. Date filed (Month, Day, Year)  AUG 1 6 2007	32. Hegistrar's Sig	nature	Me						

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notation as

Baltimore, Maryland 21215-0036

sician and burial-transit attending physician as the use Po signed by the a has this certificate

requires that the death certificate be executed

ö Hospital

Division or Vital Records, P.O. Box 68760,

Examine Completed by Physician/Medical Be the Funeral Director: After the properties of the funeral mpletely filled in by the funeral death within 24 hours after death to the Funeral Director:

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Certification:

Medical

Part II. Other significant conditions Hypotension	contributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?  No 3 □ Probably 4 □ Unknown		
End Stage Re	nal Disease			24a. Was an autopsy performed? 1  Yes 2  No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No		
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	]ER/Outpatient 3☐ I	th (Check only one) ome 5 Residence 6	(Check only one) ne 5 ☐ Residence 6 ☐ Other (Specify)			
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred .		
3 Suicide 6 Could not 4 Hornicide determine			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	Physician: To the best of my known aminer: On the basis of examination						

29c. License number

MA52120

1500 Forest Glen Rd. Silver Spring, Md. 20910

29d. Date signed (Month, Day, Year)

August 15, 2007

State Registrar

Shailesh Sheth M.D. 31. Date filed (Month, Day, Year)

AUG 1 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Frint)

29b. Signature and title of certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Mary Christine Pecoraro August 15, 2007 5:30P ^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Casey House Rockville Montgomery | ROCKVILLE | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 17, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 79 215-48-8050 1927 Washington D.C Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City. Town or Location a or 28a-f show t be notified at 10b. County 10d. Inside City Limits 1 ☐ Yes X No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10009 Forest Grove Drive 20902 r than "natural", or items 23a the Medical Examiner must the U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County College (1-4or 5+) Elementary/Secondary (0-12) School Crossing Guard Police Department permit. Pages 1 and 2 should be filed be Department of Health and Mental Hygis Important: If Item 27 is marked other any Injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elvira Mastrolaeasa ၉ Gabriel Joseph Fontana 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Pecoraro - Son 824 Buckingham Road, Cumberland, Maryland 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 8/21/07 | Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland 21. Signature of Fun rai Service Ligensee 20872 overt 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Gallbladder Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami attending physician and for use as the burial-trar Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🔀 No been signed by the should be detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? X No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an s certificate has birector, page 2 s autops, performed? 2**X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$ Other (Specify) Hospice This c 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 10 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: After thi funeral

within 24 hours after death.

To the Funeral Director: /

Certification: 2 Accident 3 ☐ Suicide 4 ☐ Homicide Medical

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signat@e and title of certified

6 Could not be determined

29c. License number

Doob4615

29d. Date signed (Month, Day, Year) August 17, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wroblewski M.D. Genevieve 31. Date filed (Month, Day, Year) AUG 2 1 2007

Registrar's Signature

1355 Piccard Drive, Rockville, Maryland

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10'SDPM Edward Kite Redman WA n1) 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Burni Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1**⊠**M 2□F Days Hours Months 88 1072071918 Virginia 225-14-9075 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Anne Arundel Odenton 1 ☐ Yes XX No MD Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? USA 21113 1303 Odenton Rd. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2**X**Xo f Yes, Give Year or Dates: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXIIo Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plastic Company Factory Forklift Operator 8 marked other permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Etta Pearl Bush Jacob Benson Redman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1303 Odenton Rd. Odenton, MD 21113 19a. Informant's Name/Relationship (Type. Print) 1303 Odenton Rd. Mabel Redman Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/18/2007 Glen Burnie, MD Glen Haven Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. all 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a nseguence of): Examiner VO Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ NQ De 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ₩ No 24a. Was an autopsy perform Yes 1□ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To f patient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? after death. I Director: After the 28b. Time of 28d. Describe how injury occurred • Catural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital t∰Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Dale signed (Month, Day, Year) ause of death (Item 23a) (Type, Print 30. Name and address of person who complete BURY 31. Date filed (Month, Day, Year) State AUG 1 7 2007 Registrar

Ledronan

Haward

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend23a per phy, DOR, 8/20/07, LDB

Certificate of Death

Reg. No. Reg. No. 2 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Katherine Northam 11:15 a^M ROW August 16 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot 29160 Krismor Court Trappe Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 X F Yrs. Director 227-24-1612 Usual Residence of Decedent July 17, 1926 Virginia 81 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Accomack Director Onancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Division Street 23417 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If item 27 Is marked other than "natural"; or Ite 1 ∏ Yes 2**∑** If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No altimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify. Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 secretary insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roland Northam Margie Matthews ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Rew husband Division Street, Onancock, VA 23417 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 XBurial 2 ☐ Cremation 3XXRemoval from State 4 ☐ Donation 5 ☐ Other (Specify) Fairview Lawn Cemetery 8/19/07 Onancock, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Thomas Funeral Home P.A. h- 45 700 Locust St., Cambridge, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2020 Sclorofie Cardio Vascular Dismane Seyegal /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, is a final conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as attending p IF FEMALE: yes, outcome pf pregnancy
□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 XNo The certificate 2□No 1 ☐ Yes 1□ Yes Atten Ing Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 VING 2**34**No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No spital or Atten Il nours after death.
neral Director: A filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar 31. Date filed (Mor.

29b. Signature and title of certifier



30. Name and ad less of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

015165

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Angela Jean Raymond 18, 2007 5:10 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 4235 Garland Avenue Nottingham Baltimore 8. Date of Birth (Month, Day, Ye If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 □ XF Months Days Hours Min. Aug 12, Director 212-50-0301 60 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nnt: If item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County notified at 1 ☐ Yes 2 🛣 No MD Baltimore Nottingham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code must be 21236 4235 Garland Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed by 3 ☐ Widowed 4 🎖 Divorced of Health and Mental Hygiene. Item 27 Is marked other than "natul other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anita Delores Ceresi Joseph Peter Raymond 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1514 5th Street NW, Washington, D.C. 20001 B. Scott Button/ son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Chesapeake Crematory 08/21/07 Beltsville, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Cause (Final Non-Small Cell Lung Metastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): P.O. Box 68760. physiciar attending p use IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) ☐ Yes 2 No certificate has been signed by the rector, page 2 should be detached 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 3 Probably 4 □Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 TYes 1☐ Yes 2 **2** Vio or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2**X**No 10 1 ☐ Yes 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 ☐ Homicide determined

the Hospital

State Registra

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Orcologis

29c. License number D0056919

certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 08/20/07

ted cause of death (Item 23a) (Type, Print N. Charles St, Baltmore M) 21204

Hober 31. Date filed (Month.

AUG 2 32. Resistrar's Signature

			For State Registrar	٠	State of Ma	aryland /	-	artment of <i>tificate d</i>			lental Hy	giene Reg. No	2007	28221
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	/Medi		Linda E		Rozzelle						August		2007 ^{ear}	12:20 AM
	Exami	ner		-	street and number)			4b. City, Tow		on of Death			County of Death	
		-	5. Social Security N	estone Dr		je (In yrs. last t	hirthday)	Ijamsv		der 24 Hrs.	8. Date of Bir		rederick	place (State or Foreign
	Funeral Director		218-52-82 Usual Residence o	210	☐M 2MTF	58	Yrs.	Months Da			Mar 17	y, Year)	Cou	nsylvania
	land w		10a. State	10b. County		10c. City, To	wn or Lo	cation						10d. Inside City Limits
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36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show he Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Mari	ried 2 XMarried	12. Was Decedent Armed Forces?  1  Yes 2 If Yes, Give Year or Dates:			Vas Decedent f Yes, specify ( I ☐ Yes 2☐X			ecify Yes or No Rican, etc.)	)-	14. Race - Ameri Black, White, Specify: Whi	, etc.
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1215-0036	s 1 and 2 should be filed within 72 hours if Health and Mental Hygiene. Item 27 is marked other than "natural", other traumatic event, the Medical Exa	Completed	Elementary/Seco	cify only highest gra	de completed) College (1-4or 5	5+)	(Give life. L	kind of work do DO NOT use re am Ana1	ne during i tired)	most of work	ing	ľ	eral Gov	·
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an	ould be t Mental I arked of	To Be			inger, Sr.	•					e Heywo		,	
Maryland	2 should be filed and Mental Hygi is marked other aumatic event, II	F		lame/Relationship (			9b. Mailin	g Address (Str	eet and Nu	ımber or Rur	al Route Numb	er, City o	or Town, State, Zi	p Code)
	1 and 2 Health a em 27 is		Edwin Wa	llace Roz	zelle/hush	oand .	3492	Firest	one I	rive	Iiamsv	ille	, MD 217	754
Baltimore,			20a. Method of Dis 1 ☐ Burial 2	position  Cremation 3	Removal from State	20b. Place ceme	tery, cren	sition (Name or natory or other	place)	1	Date .		ocation - City or T	
Ħ	permit. Page Department of Important: If any Injury or once.			5 ☐ Other (Specification of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the followi		Ches	apea	ke_Crem	atory	7: 08/2	1/07	Belt	sville,	MD
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	Physician		Immediate Cause	(Final									multig	Onset and Death
	/Medical		resulting in death)		aoue to (or as	J5 consequence	e of):	d	, , ,	No.	, ,,,,,		noi Co	MO
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68760,	tificate be executed ig physician and as the burial-transit	edical			<b>-</b> d									
P.O. Box	death cer e attendir d for use	Physician/M	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknowr	2 months?	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea		Ectopic pregna Other <i>(specif</i> y				ļ	23d. Date of deliv Month	very Day Year
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	ng ffer inei	ion	27. Manner of Dea 1 Natural	5 Pending	28a. Date of Inju (Month, Da		D. Time of Injury		njury at Nork? I ∐ Yes ∷		28d. Describe	how inju	ry occurred	
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigatior 6  ☐ Could not be determined	28e. Place of inj	ury - At home, tc. (Specify)	farm, stre				28f. Location ( City or To			ral Route Number,
	pital		29a. Certifier	1 Certifying Ph	yslcian: To the best	of my knowled	lge death	occurred at th	e time dat	e and place	and due to the	causo/s	) and manner as	stated
	the Hos in 24 ho the Fun pletely	Medical	(Check only one)		niner: On the basis o and manner st	of examination		vestigation, in r	ny opinion,	death occur		, date an	d place, and due	to the cause(s)
	To COLL	Σ	29b. Signature and	title of certifier	- 1			29c. Lic	ense numb				te signed (Month	•
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(8)	ra-		30. Name and add		completed cause of d		_		ے لیے	~	~ /		1 mh	2/70/
	St	ate	31. Date filed (Mor	nth. Day, Year)	32. Resistr	ar's Signature		2 11	5		al	7 -7C.	> 100	2/10/
	Regist			AUG 2 1	2007 Acas	ar's Signature		Coull !						

State of Maryland / Department of Health and Mental Hygien 👂 👔 28222 1 - For Stata Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 19, 2007 3:45 p Pearl Y. Ricketts Aua /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Potomac Valley Wellness & Nursing Center Rockville 7. Age (In yrs. last birthday) If Under 1 Year | Il Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 🖫 F 93 PA 579-36-4743 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b. County ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes XXNo Director MD Montgomery Kensington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3618 Littledale Road, Apt 214 20895 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married White 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth eny linjury or other treumatic event 90.68. 17. Father's Name (First, Middle, Last) Be Virginia 2 Adam Yarnall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 809 Waterford Road, Silver Spring, MD 20901 Ross S. Lenet /Friend Aug 21 ate 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 4 ☐ Donation 5 ☐ Other (Specify) Laytonsville Cemetery Laytonsville, MD 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd W, Silver Spring, MD 20901 Approximate Interval Between Inset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician nellate /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consaquence of) Examine inding physicien and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown ete hes been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Wunknown Completed 24a. Was an autopsy performed? 24b. Were autopsy lindings available prior to completion of cause of death?

1 □ Yes 2 □ No this certificate has Hospitel or Attending Physician: 24 hours after death. Funerel Director: Atter this certifice 25. Was case referred to medical 26. Place of Death (Check only one) funeral director 2 Hospital: Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 2 1 🗌 Yes 27. Manner of Deal 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D Contifying Physician: To the best of my knowledge death occurred at the time, date and place; and die to the muse(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number and title of certifier 29b. Signatura 30. Name and address of person search Blup 10 401 ra 31. Date liled (Month, Day, Year) 32. Registrar's Signature State AUG 2 1 2007 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Lexia Helen Richardson August 6:1 14,2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Doctor's Community Hospital Prince Georges Lanham If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 1913 Bennettsville, C 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Months Days Hours 1 M 2 F 577-34-8434 94 Jan. 31, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 X Yes 2 □ No Maryland Prince Georges Landover 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 Jonquil Ave. 20785 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Custodian D.C. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hossica Conwell Helen Odom 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7830 Hanover Parkway #103 Greenbelt, Md. Helen Johnson / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Aug 31,2007 | Arlington, Va. 4 Donation 5 Other (Specify) Arlington National 22 Name and Address of Facility Alexander S. Pope P.A. 5538 Mariboro Pike/Forestville, Md. 21. Signature of Funeral Service Licensee 20747 23a. /2r1. Inter the diserse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only on cause on each line. Immediate Cause (Final DAYS resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DIGI Due to (or as a consequence of): ONGES 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

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After this certification, I

after death.

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within 24 hours after To the Funeral Di completely filled ir

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Certification:

Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records,

O. Box 68760

**Physician** 

/Medical

Examiner

**Funeral** 

Director

rai", or items 23a or 28a-f show Examiner must be notified at

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important; if Item 27 Is marked other any injury or other traumatic event, the once.

1 and 2 should be Health and Mental

Directo

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death with the Maryland

Baltimore, Maryland 21215-0036

Examine Physician/Medical 2 Completed

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

1 Inpatient 28a. Date of Injury

2 ER/Outpatient 3 DOA 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 | Yes 2 | No 3 | Probably 4 | GHIKnown

27. Manner of Death

2 Accident

3 ☐ Suicide

4 ☐ Hornicide

5 ☐ Pending investigation

(Month, Day Year) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. SINGH 7209A HANOVER PKWY GREENBELT MD 2077.

State Registrar 31. Date filed (Month, Day, Year) 7 2007 AUG 1

32. Registrar's Signature

7-06644 Pamela Sue Shriver

M€

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 28224

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xamir	пег					SUE S	HRIVE	R	y, Town, or I	coation of		August 27	4c. County	of Death		
		4a. Facility Name	(if not institution	on, give street	and number	er) vardner Rd		1	y, rown, or i neytown	Location of	Death		Carroll			
		Keysville F		6. Sex	T7 /	Age (In yrs. las	st birthday)		inder 1 Year	If Under	24Hrs.	8. Date of Bir	th(MM/DD/YYY	g. Birthp Foreign	lace (Sta	ate or
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arylan 8a-f si	Director	10e. Street and I	lumber		11 57			10f.	. Zip Code						у.	
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	icate physi	edicai		d										
0 X 6	The law requires that the death certificate has been signed by the ettending phoage 2 should be deteched for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant			of pregnancy					-35	23d	Date of delive	irv
O O	death he ette ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 🗆		2 🗌 Fetal deat t time of death		ic pregnancy r (specify)						Day Year
P.O.	hat the d by ti letech	Phy	9 Unknowh				(= 4b =			_	00. 0:44			
ار طع. ا	w requires that the de been signed by the should be deteched		Part II. Other significant conditio		y to death b	out not resulting	in the underly	ng cause give	en in Part I.		1			ably 4 Tunknown
ecords.	w req	iete		36-7		, .					24a. Was			
<u>ँ</u> ऽ <b>८</b>	The law cate hes page 2.9	Completed						<u> </u>		_	autop perfor	sy med?	death?	osy findings available inpletion of cause of
کاماہلا Vital Re		BeC	25. Was case referred to medical examiner?						26. Place o	of Death	1 ☐ Yes (Check only or		1 🗌 Yes	2 No
-	Physicien: this certificatal director, p	P.	1 Yes 2 No	Hospital	1 U Inpatie	ent 2 ERVO		DOA Othe	4 L IVUIS		e 5 ☐ Resid			")
	ding I h. After funer	tion;	27. Manner of Death  1 ☐Natural 5 ☐ Pending 2 ☐ Accident investig		Date of Inju (Month, Da	y Year) 28b.	Time of Injury	28c. Injury Work	/at <br Yes 2.∐N		8d. Describe h	ow injury o	curred	
My/The Division o	Atten r deal ector: by the	ifica	3 ☐ Suicide 6 ☐ Could n	ot be	Place of Inj	ury - At home, f							umber or Rura	I Route Number,
	tel or rs efte el Dir	Certification;	4  Homicide determi		building, et	c. (Specify)					City or Tow	n, State)		
	To the Hospitel or Attending Physicien: within 24 hours elfer death. To the Funerel Director: After this certific completely filled in by the funeral director,	Medicai	29a. Certifier 1 Certifyin (Check only 2 Medical to	xaminer: On	To the best the basis o I manner st	of my knowledg f examination a ated.	ge, death occu nd/or investiga	rred at the tim ition, in my or	ne, date and pinion, death	place, a	nd due to the o	ause(s) and late and pla	manner as st ce, and due to	ated. the cause(s)
	To the within To the comp	Ň	29b. Signature and title of certifier	18	/	4 1		29c. License	number		4	29d. Date/si	gned (Month,	Day, Year)
			1/1/2	Lows	4	theut		1981	30			8/2	0/0+	
	3A5		30. Name and address of person v	no complete	cause of d	leath (Item 23a)	(Type, Print)	11 11	1		0 1		2	3/1
ı	Sta	te	31. Date filed (Month, Day, Year)	vinas	32. Registr	Jacob (Item 23a) 2 U W 000 ar's Signature	× 7733	M= 170	ing /ch	We	Ber/	n, 41	) 2/8	7/
	Registr	_	AUG 2	2007	Klas	we to	Rose							

			For State Registrar	State o	of Marylan		rtment of H tificate of L				007	28226
	Physicia	an	1. Decedent's Name (First, Middle,	Last)					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al .	EMMA	SPANGLE		1	41. O'2. T-	I	AUGUST	17	2007	6:18 P M
	Examin	er	4a. Facility Name (If not institution, FREDERICK MEMO)	-			FREDERI	Location of Death			ounty of Death EDERICK	
	Funeral Director		5. Social Security Number 353–18–2435	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 8		If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da Jan 1	y Year) 2, 19	9. Birthi Cour Ken	place (State or Foreign ntry) Lucky
	w and		Usual Residence of Decedent  10a. State 10b. County		T10c, Cit	y, Town or Lo	cation					10d. Inside City Limits
	Maryla f sho ed at	5	Maryland Freder	cick		ederic						1√∑Yes 2 □No
	r 28a-	irec	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cou	ntry?
	th with	Funeral Director	315 East 9th St	eet			21701			U.	S.A.	
	ems er mu	ner	11. Marital Status	Armed Fo	edent Ever in U	.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14	I. Race - Americ Black, White,	
30	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notifled at	by Ft	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes If Yes, Gi Year or D	2 No ive X		l □ Yes 2 No	Specify:			Specify: Whi	
5-0036	hour stural		15. Decedent'		Jales.	16a. Deced	lent's Usual Occupa	ation			d of Business/In	
2 1 2	within 72 ene. than "na' he Medic	plet	(Specify only highest	t grade completed)	1-4or 5+)	Give life. I	kind of work done o OO NOT use retired	luring most of worl )	king			
77	ed with	Completed				] ]	Homemaker				wn Home	
Maryland	ld be filed within 72 hours after death with the Marylar lental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, L					18. Mother's Nam			urname)	
<u> </u>	Mer arke	္	O'Bannon Routin  19a. Informant's Name/Relationsh			10b Mailin	g Address (Street a	Julie S			Town State 7i	n Codo)
Σ	nd 2 s Ith ar 27 is 1rau		Donald C. Spang		band		ast 9th S					
ā,	iges 1 and 2 nt of Health a it item 27 is or other trai		20a. Method of Disposition		20b. F		sition (Name of natory or other place		Date		ation - City or T	
E	Pages nent of int: If its iry or o		1 XBurial 2 □Cremation 4 □Donation 5 □ Other ( <i>Sp</i>		i State I		Nat. Cem	i i	12/07	Ft. M	yer, Vi	rginia
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Juneral Service L	icensee	090	Ri	Name and Address OBERT E. 201 NORTH	SS OF FacilitY DAILEY &	SON, FU	NERAL	HOMES,	P.A.
			23a. Part1. Enter the disease, or shock, or heart rellure. List	complications that	c used the deal						CR, III_	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	A	eule	Rema	2 Farles	me				Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseq							
É	Examine	_	Sequentially list conditions, if any, leading to immediate	b. Due t	(or as a conseq							4 Dany
	nted nsit	Examiner	Cause (Disease or injury	Due to	(or as a conseq	quence or).						
,	be executed sician and burial-transit	Еха	that initiated events resulting in death) Last	CDue to	(or as a consec	juence of):						
8760,	icate be executed physician and s the burial-transit	dical		d								
9	ertifica ing ph e as th	Med	IF FEMALE:	1								
Box	death certifi e attending p d for use as	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	utcome pf pregn birth 2 ☐ Feta	al death 3	Ectopic pregnancy			23	Bd. Date of delive Month	very Day Year
	0 0	Physician/Me	1 ☐ Yes 2 No 9 ☐ Unknown	4⊟Preg 9⊟Unki	nant at time of one	death 5	Other (specify)					
J.	The law requires that the de tte has been signed by the a lage 2 should be detached f	y Ph	Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco us	e contribute to	the cause of death?
Vital Records,	w requires been sign should be	ed by							10	Yes 2	No 3□Pro	bably 4 Unknown
ပ္တ	e law re has bee je 2 sho	Completed							24a. Was		24b. Were aut	opsy findings available
ř		m oʻ								rmed?	death?	2 No
/Ita	sician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	Licenitel			l Oil	26. Place of Dea	th (Check only	one)		
	Physician: r this certifica ral director, I	To.	1 ☐ Yes 2 No  27. Manner of Death	Hospital: 128a. Date		ER/Outpatier		4 □ Nursing H	ome 5 ☐ Resi			ify)
on	iding F h. : After : funer	tion	1 Natural 5 Pending 2 Accident investig	(Mo	nth, Day Year)	Injury	Wor	k? Yes 2 □ No	Edd. Describe	rion injury	oodiica	
Division or	Atter r deal ector by the	ifica	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Plac	e of injury - At h	ome, farm, str	eet, factory, office		28f. Location ( City or To	Street and	Number or Ru	ral Route Number,
	tal or rs afte al Dir	Certification:	4 Distincte	Dull	uing, etc. (Opeci	·y/			City di 10	wii, State)		
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral	Medical		g Physician: To th Examiner: On the and ma	basis of examination	ation and/or in	vestigation, in my o	pinion, death occu	irred at the time	date and	place, and due	to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier	X			29c. Licens	e number		29d. Date	signed (Month	, Day, Year)
				4			2	)43091		S-	15-0	7
	5		30. Name and address of person	who completed cau	use of death (Ite	m 23a) (Type,	Print) TOLL	House	Ave	, +	rederic	, Day, Year) 7 (Le, MD)
	Sta Regist		31. Date filed (Month, Day, Year) AUG 2 1	2007	egistrar's Sign	ature	new					/

				Please	Type or Pr							•		_	ble.	
			For State Registrar		State of N	/laryland		artmen <i>rtificat</i>				lental Hy			0.7	00007
	6		Registrar     Decedent's Nam	ne (First, Middle, La	ast)		001	incat	COIL	Jean		2. Date of D			U	3. Time of Death
16	Physicia /Medic	-	Jean C	atherine	Shaffer						Δ.	Month	2007		Year	9:45 a
	Examin	_		A CHARLES MAN AND A CO.	ve street and numbe	r)		4b. City,	Town, or	Location	of Death	-9			of Death	
å			520 Haw 5. Social Security N	vkesbury		Age (In yrs. I	ast hirthday)	Si]	ver		ng r 24 Hrs.	8. Date of Bi		ntgc	mery	lace (State or Foreign
	Funeral Director		579-30-1		1 □ M 2 🛣 F	78	Yrs.	Months	Days	Hours	Min.	Jan 5,	ay, 1 ^{Year)}	9	Cour	nace (State of Poreign
	ם פ		Usual Residence of	f Decedent		1.0										
	larylar show	'n	10a. State	10b. County			, Town or Lo								1	0d. Inside City Limits 1 ☐ Yes ※X No
	the N 28a-f notifie	Director	MD 10e. Street and Nu	Montgom	ery		Silver S	5pring 10f. Zip	Code		-		10a. Citi	izen of V	What Cour	
	n with			sbury Lane					904					JSA		,.
	death	Funeral	11. Marital Status		12. Was Deceder Armed Forces	= ?	S. 13.			spanic O	rigin? (Sp	ecify Yes or N Rican, etc.)	0-		e - Americ	
92	s after , or Ite amine	by Fu	1 ☐ Never Marr 3 <b>X</b> Widowed	ried 2 Married	1 ☐ Yes 🏖	No No	i	1 ☐ Yes	_	Specify		rnoan, etc.)		Specify	What	_
5-0036	should be filed within 72 hours after death with the Maryland di Mental Hygiene. marked other than "natural!" or Items 23a or 28a-f show matic event, the Medical Examiner must be notified at	q pa	3A Widowed	15. Decedent's E	Year or Dates	s: 	16a. Dece	dent's Usu	al Occupa	ation			16b Ki	ind of Bu	usiness/Inc	dustry
75	nin 72 s. In "ne Medic	Completed	(Spec	cify only highest gr	rade completed)  College (1-4o	r 5±\	(Give	kind of wo DO NOT u	rk done d	turina mo	st of work	ing			20110007111	
2	filed with Hygiene the the the the the the the the the th	Com	12				Persa	nnel M	anagei				Gove			
ng	~ 0 9	Be	17. Father's Name									e (First, Middle		Surnan	ne)	
Maryland 2121	hould d Mer marke matic	ဥ		vard Schmid			10h Mailir	na Address	/Street s			ie Smith a <i>l Route Num</i>		or Town	State 7is	Codel
Ma	nd 2 s lith an <b>27 is</b> i			affer /Dau								ville, M		`	State, Zip	Code
e,	of Hear item othe		20a. Method of Dis	position		0.	lace of Dispo	sition /Na	ne of			Date			City or To	own, State
altimore,	Page ment ant: If ury o			5 ☐ Other (Speci	□Removal from Stat ify)	te	opolita	n Cirem	atory	, A	ng 21 2007		Alexar		•	
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		21. Signature of Fi	uneral Service Lice	ensee											ome, Inc.
	0.01 = 10.01		23a Part 1 Anter 1	the disease or con	nplications that caus	ed the death						ilver Sp		MD 2	20901	Approximate
	Physician		shock, or hea Immediate Cause	art failure. List only (Final	y one cause on each	line.									2	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	on 🕜	a. Due to (or a	(NG- as a consequ	uence of):	4NC	ere	- (1	NON	-Soup	HLC	8	9	LYGHR
	Examiner		Sequentially list co	onditions	b											
	ed sit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate erlying	Due to (or a	as a consequ	uence of):									
	be executed cian and ourial-transit	xan	that initiated events resulting in death)	S	c. Due to (or a	as a consequ	uence of):									
760,	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit			(	d.											
687	rtificat ng phy as th	<b>Jedi</b>	IE EENAN E													
Box	ath ce ttendii or use	ian/l	IF FEMALE: 23b. Was deceder in the past 12		23c. If yes, outcon 1 ☐ Live birth	2 🗆 Fetal	Ideath 3	⊒Ectopic p							te of delive	ery Day Year
P.O.	the de	Physician/Medical	1 ☐ Yes 23 9 ☐ Unknown	<b>©</b> No	4□Pregnant 9□Unknown		eath 5[	Other (s)	pecify)				i	IVIC	,,,,,,	Day
	ires that the de signed by the a be detached		Part II. Other signi	ificant conditions	contributing to death	but not resu	ulting in the u	ınderlying (	ause give	en in Part	I.	23e. Did	tobacco	use conf	tribute to t	he cause of death?
Vital Records,	w requires been sign should be	ed by										хX	Yes 2	□ No	3 ☐ Prob	pably 4 □Unknown
ဝ၁	ne law re has bee ye 2 sho	plet								_		24a. Wa	s an opsy	24b.	Were auto	ppsy findings available mpletion of cause of
Ē.		Completed											formed?		death?	2 No
Vita	Ician: Sertific ector,	Be	25. Was case refe examiner?		Hospital:				l Oth		e of Deat	h (Check only	one)			
or	Physician: The la r this certificate has ral director, page 2	٠ <u>۲</u>	1 X Yes 2 ☐ 27. Manner of Dea		28a. Date of I		ER/Outpatier 28b. Time o			4 🗆 🗅	lursing Ho	me 🙀 Res 28d. Describe				(y)
on	Jing Afte fune	Certification:	1 X Natural 2 ☐ Accident	5 Pending investigation	(Month, I	Day Year)	Injury	М	28c. Injun Worl 1 □ 1	k? Yes 2[	]No	Lou. Docombe	o rion inju	ry 00001	rou .	
Division or		tifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	20e. Flace UI	injury - At ho etc. <i>(Specif</i> )		reet, factor	y, office				(Street ar		per or Rura	al Route Number,
	Hospital or Attenc 44 hours after death Funeral Director: tely filled in by the			·												
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one)		hysician: To the be miner: On the basis and manner	of examinat										
	To the within 2 To the complet	Me	29b. Signature and	title of certifier	0 0	7		29	c. License	e number			29d. Da	ite signe	d (Month,	Day, Year)
)	0		1 fa	ul 2	Hamle	Omo		.   .	Doc	761	08	3	AC	16	20	,2007
~	),2		30. Name and add	Iress of person who	completed cause o	f death (Item	23a) (Type,									
7	Sta	te	Paul Thamb	i, M.D., 97	707 Medical	Center strar's Signa	Dr. Sui	te 300	, Roc	kvill	e, MD	20850				
	اد Registi			AUG 2 1			K A	bort	9							

1 € M 2 □ F

Yrs.

For	State of	of Maryland / Depa	artment of H	lealth and M	lental Hygi	ene			
For State Registrar		Cei	rtificate of l	Death	Re	g. No. 2	107	282	28
1. Decedent's Name (First, Middle William)	e, Last) Eugene	. Sche-	Her		2. Date of Death Month	Day	Year 2007	3. Time of Dea	ath M
4a. Facility Name (If not institutio			4b. City, Town, or	Location of Death		4c. Count	y of Death		
Renaissance Gardens	@ Riderwoo	d Village	Silver S	Spring		Montg	omery		
<ol><li>Social Security Number</li></ol>	6. Sex	7. Age (In yrs. last birthday)		if Under 24 Hrs.	8. Date of Birth	V1	9. Birthpla	ice (State or Fo	reign
217 26 0526	1 € M 2 🗆 F	Yrs.	Months Days	Hours Min.	(Month, Day,	rear)	Countr	y)	

20904

**Funeral** Director

/Medical

Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the HospItal or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	317-26-8	039	XIM 2LIF	_86	Yrs.	Wortins Days	Hours	Aug 24	, ,	IN	nu y)
	Usual Residence of 10a. State	10b. County		10c. City, To	wn or Loca	ation					10d. Inside City Limits
-	Tod. Glate	Tob. County		100. Oity, 10	WITOT LOCK	111011					1 ☐ Yes XIX No
Sct	MD	Montgome	ry	Silv	er Sp						
Funeral Director	10e. Street and Nu	mber				10f. Zip Code			10g. Citizer	of What Cou	ntry?
<u>a</u>	3122 Gr	acefield	Road, CT	117		20904			US	A	
I Pe	11. Maritai Status		12. Was Deceden Armed Forces	t Ever in U.S.	13. W	as Decedent of H	lispenic Origin?	(Specify Yes or Nierto Rican, etc.)		Race - Ameri Black, White,	
		ied 2 Married	1X Yes 2	] No		JYes 2XINo		1010 1110411, 010.)		ecify: Who	
d b	3 Widowed	4 Divorced	Year or Dates	WW II		1103 2221140	орвану.		Sp	ecny: wii-	rce
Completed by		15. Decedent's Ed	ide completed)		ia. Decede (Give ki life. De	nt's Usual Occup ind of work done O NOT use retire	oation during most of u d)	working	16b. Kind	of Business/In	dustry
Ē	Elementary/Seco	ondary (0-12)	College (1-4or	,		al Illus			Gove	rnment	
Ü	17. Father's Name	(First, Middle, Last		1 2 2	CUICC	ir riius		Name (First, Middle			
Be c	7	<b>~</b>	h - 4 4 7						_	,	
2	Jacob	ame/Relationship (	hettler	1,0	Oh Mailina	Addross (Ctrost	Elsie		Brya		. 0 - (-)
	19a. miormant S N	ame/neialionship (	type. Filiti)	''	ab. Mailing	Address (Street	and Number or	Rural Route Num	oer, City or T	own, State, Zij	O Code)
		Schettle	r /Wife	31	22 Gr	acefiel	d Road,	CT 117.			ng, MD 20904
	20a. Method of Dis		Removal from Stat		tery, crema	atory or other pla	ce)	Date	20c. Locat	ion - City or T	own, State
		5 ☐ Other (Specif			n Memo	rial Park	Aug	22, 2007	Rockvi]	le, MD	
	21. Signature of Fu	uneral Service Licer	rsee			Name and Addre					
	20	2 com	Dan Can		Fre	ncis J. C	ollins ru	neral Home	, inc.	<b>5</b> 00001	
	23a. Part1. Inter t	he disease, or com	plications that can a one cause on ach	the death. Do	o not enter	the mode of dyi	ng, such as card	liac or respiratory	arrest,	9) 21/36/IE	Approximate
	Immediate Cause	rinai	one cause on lach	OVIN	Cod	SD	155-1	255			Interval Between Onset and Death
	disease or condition resulting in death)	in .	a			- <i>v</i>		1		_	10/0/0
			Due to (or a	s a consequenc	e or):					1	
h	Sequentially list co	nditions,	b. The to frame	S a consequenc	0.190					_	
Ē	cause. Enter Under Cause (Disease or	erlying	240 10 (01 4	o a consequenc	c 01).						
Examiner	that initiated events resulting in death)	3	C	s a consequenc	0.01):			-		1.	
Ü			Due to (or a	s a consequenc	e oi).					1	
dica			d								
Mec	IF FEMALE:										
pleted by Physician/Medical	23b. Was deceden		23c. If yes, outcom 1 ☐ Live birth	e pf pregnancy 2  Fetal dea	th 3∏8	Ectopic pregnanc	v		23d	. Date of deliv	•
sici	in the past 12 1 ☐ Yes 2 [	□No		at time of death		Other (specify) _				Month	Day Year
Ϋ́	9 Unknown		3 HOTINIOWIT								
Ϋ́	Part II. Other signi	ficant conditions	contributing to death	but not resulting	in the unc	lerlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to t	the cause of death?
b								_ 1 🗆	Yes 2	lo 3∐Pro	babiy 4 ☐Unknown
ete								24a. Wa	s an	Mb Ware sut	opsy findings available
							<del></del>	— auto			ompletion of cause of
Com								1□ Yes	No	1 ☐ Yes	2 No
Be	25. Was case referexaminer?	red to medical	Hospital:			011		Death (Check only			
P	1 Yes 2	No	1   Inpa		Dutpatient	3□ DOA Oth	Nursin	g Home 5□ Res			fy)
iio	27. Manner of Deat 1. Natural	th 5 ☐ Pending	28a. Date of In (Month, D		. Time of Injury	28c. Inju	ry at rk?	28d. Describe	how injury o	ccurred	
ati	2 ☐ Accident	investigation				M 1□	Yes 2 ☐ No				
ţį	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	20e. Flece of I	njury - At home, etc. (Specify)	farm, stree	et, factory, office		28f. Location City or To	(Street and Nown, State)	lumber or Rur	al Route Number,
Cer			di .					10			
Medical Certification:	29a. Certifier (Check only	Certifying Pi	ysician: To the bes	t of my knowled	ge, death	occurred at the ti	me, date and pl	ace, and due to the	e cause(s) an	d manner as	stated.
ggi	one)	∠ iviedicai Exai	niner: On the basis and manners	stated.	and/or inve	ssugation, in my	opinion, death o	ccurred at the time	e, date and pl	ace, and due	to tne cause(s)
Ž	29b. Signature and	tive of certifier	7/11			29c. Licens			29d. Date s	igned (Month,	Day, Year)
		de la	leex	Re		DZ	409	3	8/	20/0	7

State Registrar

nth, Day, Year) AUG 2 1 2007

who completed cause of death (Item 23a) (Type, Print)
HURSTMD 3116 GRACEFIED RD SILVER SPHNGMD

Physicia /Medica		1. Decedent's Name (First, Middle, Las			Ce	пітіса	te ot l	Death			Reg. No.	001	282	4:
/IIICalca	_	Geor	,	rt	Schu1	z				2. Date of De Month August	Day	2007	3. Time of 1 5:17A	Death M
Examine	er	4a. Facility Name (If not institution, give	,					Location o	of Death		4c. 0	County of Death		
uneral		Ft. Washington Hos	7. Ag		ast birthday)		r 1 Year	ingto	24 Hrs.	8. Date of Birt	h	nce Geo	rge place (State or intry)	Foreig
Director	_ L	082-22-7805 13 Usual Residence of Decedent	Фм 2□ F   7	6	Yrs.	NOTITIES	Days	Hours	IVIII I.	Feb. 25	,1931	New	York	
Mot W		10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside Cit	y Limit
r 28a-f ehow	cto	Florida Flagler		Palm	n Coas	t							1 ☐ Yes	2. N
or 28	Dire	10e. Street and Number				10f. Zi	p Code					en of What Cou	ntry?	
0 23a	a l	35 Wildwood Drive	10 Mar Davidson	5	3 40			32137			USA			
0 3	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ∑Yes 2 ☐ If Yes, Give Year or Dates:		1-	was Dece If Yes, spe 1  Yes	~~		gin? (Spe i, Puerto F	cify Yes or No Rican, etc.)		4. Race - Amer Black, White Specify: Whit	, etc.	
	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	175.	16a. Dece	kind of wo	ork done c	turina mast	t of workin	na	16b. Kin	d of Business/Ir	ndustry	
- 22	m d	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT L	ise retired	)				1.0		
other the	ပို့ -	17. Father's Name (First, Middle, Last)	1		Elec	troni	c Te	chnic 18. Mothe		(First, Middle,		eral Go	vernmen	ıt_
arked o	To Be	John Schulz						Edna		Hahn				
EE		19a, Informant's Name/Relationship (T										Town, State, Zi		
ther i	- 1	Marian K. Schulz/W 20a. Method of Disposition	rre	20b. Pla	ace of Dispo		and the same of	r. Pa.		oast, F		da 3213 ation - City or T		
Important: if item 27 is any injury or other tra once.		1 ☐ Burial 2 ☐ Cremation 3 🕅 4 ☐ Donation 5 ☐ Other (Specify,		Ce	metery, crei nland	matory or o	other plac					sville,		- l
Injur	ŀ	21. Signature of Funeral Service License		111261								Funera		ску
any ir		ARP. Ka	las 1	à								id. 2074		
attending physicien and for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  Due to (or as  Due to (or as	a consequ	ence of):					3				
tached for use as th	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3[	∃Ectopic p ∃ Other (s					23	3d. Date of deliv	•	ear
ld be detac	d by P	Part II. Other significant conditions co	ntributing to death b	ut not resu	lting in the u	nderlying o	cause give	on in Part I.		23e. Did to	× 1	e contribute to	the cause of de	
pege 2 should	ompiete										raned?	24b. Were aut prior to co death?		vailab iuse o
certificate rector, peg		25. Was case referred to medical						26 Place	of Death	1 ☐ Yes	2 No	1 ☐ Yes	2□ No	
this certific al director,	9	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatie	ent 24LE	R/Outpatier	nt 3□ D0	OA Othe					Other (Speci	fy)	
r. After the funera		27 Manner of Death 1 Panatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	f s	28c. Injury Work		2	8d. Describe i				
To the Funerel Director: After this completely filled in by the funeral dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At hor c. (Specify)	me, farm, str	eet, factor	y, office		2	8f. Location (5 City or Tox	Street and vn, State)	Number or Rur	al Route Numb	)B <i>r</i> ,
Funer etely fill	Medicai	29a. Certifier   7 Certifying Phy (Check only one) 2   Medical Exam	sician: To the best iner: On the basis o and manner st	examinati	rladge, deatl on and/or in	n onnumed vestigation	at the tin	e data and pinion, deat	d plane, a th occurre	nd due to the id at the time,	date and p	ind manner de l blace, and due i	stated. to the cause(s)	
To the	<u>₹</u>	29b. Signature and title of certifier				29	c. License	number			29d. Date	signed (Month,	Day, Year)	
		1 Parla	- M.O.			I	00	53	117			8/1101	07	
)		30. Name and andress of person of o	ompleted cause of d	eath (Item	23а) (Туре,	Print)						1.01		
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30. Name and address of person wh

Year)

31. Date filed (Month, Day,

AUG 1 7 2007

TURAPOLIS

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sanchez Silvia L. Aug. 15, 2007 10;15a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 🖫 F Months Days Hours Min. *5*9717.69.1956 none 51 Ecuador Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show iral", or items 23a or 28a-f shov Examiner must be notified at MD 1 Yes 2 No Montgomery Germantown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20034 Frederick Road #23 20876 Ecuador Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1X Yes 2 No Specify: Ecuadorian þ Specify: White 3 ☐ Widowed 4 Divorced "natural", Completed other traumatic event, the M-Jical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi Be Gonzalo Sanchez Ana Guaderos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an Andrea Herrera/Daughter 20034 Frederick Rd #23 Germantown, Md. 20876 permit. Pages 1 a Department of Her Important: If item 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 □ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cemeterio de Quito8/31/2007 Quito, Ecuador any injury 21. Signal of Funeral Service PHILIP ACCESSITATION FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Breast Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or rijury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transi and Due to (or as a consequence of): Box 68760, ed by the attending physician detached for use as the buris certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) P.O. I ☐Yes 2☐No 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? page certificate 1 Yes 2 No Physician: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 MOther (Specif ) OSPICE 1 ☐ Yes 2 ☒ No 1 Inpatient 2 ER/Outpatient 3 DOA this 2 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 ☐ Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOL August 15,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wrobleski MD 6001 Muncaster Mill Rd Rockville, Md 20855 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Ruth Simon <u>11:</u>13 Α. 12 2007 Aug /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Nursing Home Prince George's Largo 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min. 1□M 2️F Hours Director 225-20-8216 85 June 18, 1922 Richmond, Va. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Maryland Prince George's 1 → es 2 No notifled Temple Hills Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ö must be Pages 1 and 2 should be filed within 72 hours after death w nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a mur, if Item 17 is marked other than "hatural", or other traumatic event, the Medical Examiner must bury or other traumatic event, the Medical Examiner must a 3515 -27th Ave. 20748 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Practical Nurse Private Duty 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unk Allen Ida 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claude D. Simon /Spouse 3515-27th Ave. Temple Hills, Md. 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If Ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Aug.17,2007 Landover, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pope Funeral Home 5538 Marlboro Pike Forestville MD 20747 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the dise/ shock, or heart failu e Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Advanced Dementia /Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Gastro Intestinal Disorder physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q icate has been sig , page 2 should b 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1□ Yes 2 **3**(No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2☐ No 1 🔲 Inpatient 2 ER/Outpatient Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1x Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 [XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062116 August 14, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7705 Belle Point Dr. Greenbelt, Md. Neklit Workneh, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

AUG 1 7 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Thomas Jerome Savoy, Jr. 12007 /Medical 4a. Facility Name (If not institution 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Tales Trunce If Under 1 Year | If Under 24 Hrs. Birthplace (State Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours Min. 509-76-9283 39 Director 26, 1967 Washington, Dec. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1X Yes 2 □ No Director Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ns 23a must b 4911 42nd Place Funeral death 20781 USA ral", or items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. In the man the man and the man is marked other than "natural", or lite may or other traumatte event, the Medical Examine my or other traumatte event, the Medical Examine 1 ∐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 None N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Jerome Savoy , Sr. ٩ Alma Laverne Allen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alma L. Allen - Mother 4911 42nd Place, Hyattsville, MD 20781 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. Resurrection Cemetery Aug. 22, 2007 Clinton, Maryland 4 Dogation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. <u>Hyattsville,</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Scizum disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buris IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has li rector, page 2 s autopsy perform 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one Certification: To funeral After

To the Hospitai or Attending Physician: ours efter death. within 24 hours e

	examiner								one only one,
		No	Hospital: 1 ☐ Inpatient	2 🗆	ER/Outpatient	3 🗆 [	OOA Other: 4 Nursing	g Home	5 Residence 6 □Other (Specify)
27.	Manner of Deat  1 ☐ Natural  2 ☐ Accident	5 Pending investigation		ear)	28b. Time of Injury	М	28c. Injury at Work? 1 □ Yes 2 □ No	280	Describe how injury occurred
	3 Suicide 4 Homicide	6 Could not be determined		- At ho Specif	ome, farm, stree	t, facto	ory, office	28f	Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one)		1 ☐ Certifying Ph 2 ☐ Medical Exar	nysician: To the best of n miner: On the basis of ex and manner stated	amina	wledge, death oution and/or inve	ccurre	ed at the time, date and pla on, in my opinion, death o	ace, and	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

29c. License numbe 29d. Date signed (Month, Day, Year)

eted cause of death (Item 23a) (Type, Print)

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State Registrar

Medical

	•	State of Maryland / Dep	partment of Health and Nertificate of Death		ne 2007	28234
		Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
Physicia /Medic	_	Donald T. Surratt		August	6 2007 ear	7:20 P M
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	25	Malcolm Grow Hospital	Andrews AFB  If Under 1 Year If Under 24 Hrs.	C Date of Right	Prince Ge	lace (State or Foreign
Funeral Director		5. Social Security Number  577-56-7819  6. Sex 1 M 2 F 7. Age (In yrs. last birthda) 1 Yrs.	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye March 18	1943 Wash	try)
yland		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or			1	0d. Inside City Limits
8e-f s	cto	Md Prince George's Suitland		100	. Citizen of What Cour	
with the		10e. Street and Number	101. Zip Code 20746	109	U.S.A.	шуг
ns 23,	eral	3709 Deming Drive  11. Marital Status 12. Was Decedent Ever in U.S. 13		pecify Yes or No-	14. Race - Amend	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Mental Hygiene. Department of Heatile and Mental Hygiene. Importent: If tiem 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, I'm Medical Exam is must be notified at anone.	by Funeral Director	1 ☐ Never Married 2 ☒ Married  1 ☐ Never Married 2 ☒ Married  1 ☐ Yes 2 ☐ No Army  If Yes, Give  Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, Specify: B1	_{etc.} .ack
72 hou nature dical E	Completed	(Specify only highest grade completed) (Gir	edent's Usual Occupation ve kind of work done during most of work	king 16	b. Kind of Business/In	dustry
within	ldm	Elementary/Secondary (0·12) College (1-4or 5+)	DO NOT use retired)  Security Guard		Government	
Hygie Hygie ther	O a	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		•
Aental Aental rked c	To Be	Thomas Surratt		Stover		
id 2 sho Ith and ? 27 Is ma			iling Address <i>(Street and Number or Rui</i> Deming Drive Suit			
es 1 an of Heal item 2 r other		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Discemetery, co	position (Name of ematory or other place)	Date 20	c. Location - City or To	own, State
Page ment ent: ti ury o		'4 □Donation 5 □Other (Specify) Arlingto			lington,Vi	
Departi Departi Import any inj once.		21. Signature Funeral Service Licensee	22. Name and Address of Facility J. 7474 Landover Road			
Medical  Medical  Mascieu aud  Mascieu aud  Medical-trausit  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medical  Medic	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):				
death certific e attending p id for use as	Physiclan/Med		B □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver Month	ery Day Year
sign Sign d be	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobai 1 ☐ Yes	cco use contribute to t	he cause of death? pably 4 DUnknow
The law requate has been page 2 shoul	Completed			24a. Was an autopsy performe	prior to co death?	ppsy findings availab impletion of cause of
	a	25. Was case referred to medical	26. Place of Dea	th (Check only one)		
Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient ②☐ ER/Outpat	ient 3 DOA Other: 4 Nursing H	ome 5 Residence	ce 6 Other (Specia	(y)
ling After fune	ertification;	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time Injury		28d. Describe how		
P P P	ertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
s Hospitel 24 hours a e Funerel C	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as s e and place, and due t	stated. o the cause(s)
To the Hos within 24 hr To the Fur completely	Me	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Month,	Day, Year)
(in)		Patter	, MDD 63094	ع	3/16/2	007
gje		30. Name and address of person who completed cause of death (Item 23a) (Type Christine M. Patton MD 1050 West Po	e, Print)	s Air Ford	ce Base, Ma	aryland 20
Sta Regist	ate rar	31. Date filed (Month, Day, Year)  AUG 1 7 2007				

			1 - For State Registrar	State of Ma	arylan	-	artment of F <i>rtificate of</i>		d Mental F		ne . No. <b>2</b> (	107	2823
m			1. Decedent's Name (First, Middle, L	ast)					2. Date of		-		3. Time of Death
	Physic /Medi			G.E. Tucker					Month August	:	Day 8	Year 2007	9:10 a _N
	Examii	ner	4a. Facility Name (If not institution, ga				4b. City, Town, o		eath	ĺ	4c. County		
	Funeral		13130 Brooktree 5. Social Security Number 6.		e (In vrs. I	ast birthday)	Lau If Under 1 Year	re1	Hrs. 8. Date of	Birth	Prin	ce Geor	ge's lace (State or Foreig
^.	Director		132-38-6546 Usual Residence of Decedent	1⊠M 2□F	75	Yrs.	Months Days		/in. (Month,	Day, Y	ear) 8,1931	Coun	ra Leone
	Dw or		10a. State 10b. County		10c. City	, Town or Lo	cation					11	0d. Inside City Limits
:	Mary fied a	ţo	Maryland Prince (	eorge's			Laure1						1 ☐ Yes 2. N
-	r 28a notil	Director	10e. Street and Number		1		10f. Zip Code			10g	. Citizen of	What Coun	try?
3	3ao st be		13130 Brooktree I	ane			20	707			U.	S.A.	
	ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.	S. 13. \	Was Decedent of H f Yes, specify Cubi		? (Specify Yes or	No-	14. Ra	ce - America	
	s I am 2 should be filed within 72 hours after beath with the maryland If Health and Mental Hygiene. Hen 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🔀 I If Yes, Give Year or Dates:	No		TYes, specify Cubi	Specify:	ueпо нісап, etc.)		Specii	ick, White, e	etc. Black
-	atura	ted	15. Decedent's I	ducation	===	16a. Deced	lent's Usual Occup	ation	_	16	 b. Kind of B	Business/Ind	
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7	Hygiene. Hygiene. Ither than	5		5+	,	I	Executive D	irector	<u></u>		County (	Governm	ent
	oe me d oth event	Be (	17. Father's Name (First, Middle, Las	t)				18. Mother's I	Name (First, Mid	die, Ma	iden Surnai	me)	
7	should be ind Mental s marked o umatic eve	ြို	Maxwell Tucker	•				S	ally Kebbi	e			
(	l and ls mg		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Street	and Number or	r Rural Route Nu	mber, C	City or Town	, State, Zip	Code)
	is I and a of Health Item 27 I		Yema Tucker - Wi	fe	Took D		Brooktree						
			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	ZUD. P	emetery, cren	sition (Name of natory or other plac	e)	Date	20	c. Location	- City or To	wn, State
è	rtant		4 □ Donation 5 □ Other (Spec	**	Gat		aven Cemete		25/2007	S	ilver S	pring,	Maryland
	Department of Important: If any injury or once.		21. Signature of Funeral Service Liga	Donne	P	I	. Name and Addre Hines-Rinal L1800 New H	di Funera	al Home, l Avenue, S	nc. Silve	r Spri	ng, Mar	yland 2090
1			23a. Part1. Enter the disease, or sor shock, or heart failure. Sist onl Immediate Cause (Final	nplications that caused one cause on each lin	the death	. Do not ente	er the mode of dyir	g, such as care	diac or respirator	y arrest	,		Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a. Renal I									Days
	xaminer		•	Due to (or as		eart Fai	ilura						Days
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La de La	d ansit	Examine	that initiated events	Metasti	ic Pro	state Ca	ancer						Years
4 4 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	an ar rial-ti		resulting in death) Last	Due to (or as	a consequ	ence of):	***			-			
bedraces and observed	physician and the burial-transit	edical		Dehydra	ation		<u></u>			_			Days
		n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d Da	ate of delive	rv
ho doods out	0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1⊡Live birth 4⊡Pregnant at 9⊡Unknown			Ectopic pregnancy Other (specify)	-		_			Day Year
The lower consistence and the	ed by detac		Part II. Other significant conditions	contributing to death be	ut not resu	Iting in the ur	derlying cause giv	en in Part I.	23e. D	id tobac	co use con	tribute to the	e cause of death?
11000	sign sign sign sign	d by	Hypertension, Hyp	erlipidemia					1	☐ Yes	2 🗆 No	3 ☐ Proba	ably 4 ⊠Unknov
200	been si should t	Completed	Oral Candidiasis							as an	24h	Were autor	sy findings availab
9	ate has page 2	Ę	OTAT CAMUTUTASTS						—   aı	itopsy erforme			pletion of cause of
			25. Was case referred to medical	1				OC Place of F	1□ Ye Death (Check on	s 2k	No	1 ☐ Yes	2□ No
Dhuoloina	is certific director,	To Be	examiner? 1  Yes 2  No	Hospital: 1 ☐ Inpatie	nt 2∏E	ER/Outpatien	t 3 DOA Oth	3r:	g Home 5⊠R		ж 6 ПО#	por /Spacific	
da Dh	h. After thi funeral (		27. Manner of Death 1 ⊠ Natural 5 □ Pending	28a. Date of Inju (Month, Day	ry	28b. Time of Injury	28c. Injur Wor	y at </td <td>28d. Descril</td> <td></td> <td></td> <td></td> <td><i>)</i></td>	28d. Descril				<i>)</i>
Attonding	death ctor:	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not l	e 28e Place of init	Inv - At hor	me farm et	M 1 □	Yes 2 □ No	204	n /C+	at and M	har or Post	Davida Altrest
à	after Direct	Certification:	4 ☐ Homicide determined	building, etc	. (Specify	)	eet, factory, office		City or	Town, S	State)	oer or Hurai	Route Number,
Loonide	within 24 hours after death  To the Funeral Director: Completely filled in by the	ledical C	29a. Certifier 1 ☑ Certifying P (Check only one)	hysician: To the best of miner: On the basis of and manner sta	examinat	vledge, death ion and/or inv	occurred at the tire restigation, in my co	ne, date and pl pinion, death o	ace, and due to to courred at the tire	he caus	se(s) and me and place,	anner as sta	ated. the cause(s)
o ebo	within to the	Mec	29b. Signature and title of certifier	Sand Halling Sto			29c. Licens	number		29d	Date signe	ed (Month, L	Day, Year)
F	170		- Λ	Soulte	M	D	D50	276				4, 2007	
	(0)	1	30. Name and address of person who		-			270		Au	Suot I	T, 2007	
	El		Sangeeta Simlote,				,	lney, Mai	ryland 208	32			
	Sta	ite	31. Date filed (Month, Day, Year)					,,					
	Regist	ar	AUG 1 6 2007	32. Registra	B. 1	parte	/						

			ricase	State of Mar	yland / Depa			•		
			1 - For State Registrar	Olato of Mai		tificate of			9. N 200	7 28236
	g (*)	J. 1	Decedent's Name (First, Middle, Las	1)				2. Date of Deat	h	3. Time of Death
	Physicia		VIRGINIA	V.	VEN	ΕY		Month August	14 2007	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			r Location of Death		4c. County of D	
			PRINCE GEORGE	с посртт	A T	Chever	1 y		D	George
	Funeral		5. Social Security Number 6. Se	7. Age (	in yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director		579 34 7391	□ M 2 🗗 8	36 Yrs.	Michigia Bayo	110010	8/30/		irginia
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Los	ration		<u> </u>		10d. Inside City Limits
	sho	ō	,		,,					1 ☐ Yes 23 No
	the A	Director	Md Prince  10e. Street and Number	George	Oxon Hil	10f. Zip Code		11	0g. Citizen of Wha	t Country?
	death with the Maryland me 23a or 28a-f show fritted be notified at									, oodiniy.
	ne 23	Funerai	5307 Livingsto	n Terrano	e #202 Per in U.S. 13. V	20745	Hispanic Origin? (Sp		U . S . A . 14. Race - A	American Indian,
		Fun	1 ☐ Never Married 2 ☐ Marned	1 ☐ Yes 2X No	"		dispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, V	Vhite, etc.
3	urs a		3√2 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 XNo	Specify:		Specify:	Black
0-003e	filed within 72 hours after death with the Marylan Hygiene ther than "natural; or liteme 23a or 28a-1 show int, the Madical Examiner must be notified at	Completed by	15. Decedent's Ed (Specify only highest grad	ucation	16a. Deced	ent's Usual Occup	nation during most of work	ana	16b. Kind of Busine	ess/Industry
V	en e	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	d)			
V	ygien ygien yerth	Cor	6 grade		Lunc	ch Aid			Private	
and	g d m ≥	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, N	Maiden Sumame)	
<u>X</u>	should ind Men s marke umatic	To	Charles E. Joh					L. Darc	C400	
Маг	C/ c/ = 0		19a. Informant's Name/Relationship (7			-	and Number or Rur			2 O 7. /s
D)	s 1 and f Health Item 27 other to		Patricia A. Kit	t, Daughi	20b. Place of Dispos	2 Asbur	y Drive	Port Date	Washing 20c. Location - City	ton, Ma
0	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐		cemetery, cren	natory or other plac	св)			nburg,Va
Бащтог	t. Pag rtment rtent: I		4 Donation 5 Other (Specify	·	Eastlawn					
g Q	permit. Departm Departm Importe eny inju		21. Signature of Funeral Service Licen:	1. 1.						JNERAL HOME
	2		23a. Part1. Enter the disease, or comp							ngton D.C
			shock, or held failure. List only of Immediate Cause (Final	one cause on each line						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	clerotic	Cardio	ovascula	r Disea	ise	
	Examiner			,	consequence of): tory Fai	luro				
- 8	. 1	er	Sequentially list conditions, if any, leading to immediate	U. —————	consequence of):	1416				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. D 1 E	1					
ĵ	ite be executed sysicien and ne burial-transit	Еха	resulting in death) Last	c. Renal F	consequence of):					
00/	ysicio	ical	(	d						
9	death certificate be ettending physion for use as the be	Physician/Medi	IF FEMALE:							
Z O	ith ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2		Ectopic pregnancy	у		23d. Date of Month	delivery Day Year
5	at the dea by the el	sici	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 Pregnant at tii 9 Unknown	me of death 5	Other (specify) _			Workin	Day (Out
Ţ.	that the ed by detacl	Phy	Part II. Other significant conditions co	entributing to death but	not reculting in the ur	dochring cause an	on in Part I	23e Did tob	nacco use contribu	te to the cause of death?
Ś	se Lb e	l by	Tarris distributions delicated to	announg to coaling to	not resuming in the ex	idonying dadda gir	on in ranci,		7.7	Probably 4 Unknown
coras	neen hout	Completed						04-115	245 114	P-4
ā	has has	mpi						24a. Was a autops	y prior ned? deat	e autopsy findings available to completion of cause of h?
	Tate ate							1 ☐ Yes 2	No 1□	Yes 2□No
=		o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	• T 500	Ott		th Check only on		
ō	Phy this raldi	<b> -</b>	1 Tyes 2 No 27. Manner of Death	1 ☐ Inpatient	2 RVOutpatien 28b. Time of		ner: 4 Nursing Ho		ence 6 UOther (	Specify)
0	ding Ith. Th.: After funer	tion	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	28c. Injui Wor M 1	rk?  Yes 2 □ No			
UNISION OF	if or Attending after death. I Director: After d in by the fune	ifica	3 Suicide 6 Could not be	28e. Place of Injur	y - At home, farm, stre	eet, factory, office		28f. Location (St	reet and Number o	r Rural Route Number,
5	i Pit e	Certification:	4 Homicide	building, etc.	(Specify)			City or Towr	i, State)	
	Hospitel			ysician: To the best of						
	the Hospiteli hin 24 hours of the Funeral I npletely filled	edicai	(Check only 2   Medical Examone)	and manner state		estigation, in my o	opinion, death occur	red at the time, d	ate and place, and	due to the cause(s)
	within 2	ž	29b. Signature and title of certifier	21/	чр	29c. Licens		2	9d. Date signed (N	*
	(1)			1	-	1000	60100		0819	-7-
	90		30. Name and address of person who o			Print) 831 T	Universi	tv Blvc	East	
	(EX)		Tshminia K.				Spring,			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	s Signature		. 0,			

State of Maryland / Department of Health and Mental Hygiens 28237 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 28 Larry Richard Warner August 2007 1:50 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospice Dove Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 2, 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign **Funeral** ^{Year)} 1948 Months Days Hours 1**X** M 2□ F Feb. 59 Director 217-50-3746 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Yes 2 No Directo ΜD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 518 N. Gorsuch Rd. 21157 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status o filed within 72 hours after dall Hygiene. Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No \$ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) building supervisor schools/county gov't. marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Carville Calvin Warner Rosey May Keeney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Warner/wife 518 N. Gorsuch Rd. Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State Taylorsville Cemetery 9/1/2007 Taylorsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ON /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year signed by the a 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy nerform 1 ☐ Yes 2 ☑ No 2 No I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury House 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D00645 30) Name and address of person who completed cause of death (Item 23a) (Type, Print) enter Street Westminster, h 31. Date filed (Month, Day, 32. Registrar's Signature State SEP 04 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 28238 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear Physician Month lliams Rohert Lee AUGUS 16 200 3:20 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DORCHESTER DORCHESTER HOSPITAL GENERAL CAMBRIDGE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)

Feb. 27, 1950 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ▼M 2 □ F 221-36-7463 Director Delaware Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Director Dorchester ambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r USAeenwood Ave by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ID Yes 2 □ No If Yes, Give Year or Dates: 1975 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status ind 2 should be filed within 72 hours after de lith and Mental Hygiene. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 1 No 3 ☐ Widowed 4 ☑ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hospita 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Maryland Be Williams Pages 1 and 2 should I virginia 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

Date

Does Does December of Court Edgewood MD.

Date

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21. Signature of Funeral Service Licensee

22. Name and Address Facility

Henry Funeral Home, R.A.

5 10 Washingtow St. Cam

23a. Part Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Department or Important: If any injury or injury or Cambridge, MD Cambridge Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PACS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown ģ tate has been signed in page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performed? Yes 2 0 No ouce Stive Physician: Was case referred to medical examinar? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 201 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a, Certifier 1 V certifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6000 0.0

DHMH 17 Rev 1/2001

Registrar

31. Date Ned (Month, Day, Year)

32. Registal's Signature

State of Maryland / Department of Health and Mental Hygiene 28239 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1715 Watkins 3 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Baltimore Marylanc If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Jan. 22, 1977 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min XX M 2 F 220-06-8735 30 Director Washington, DC Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at Calvert Maryland Dunkirk 1 ☐ Yes ŽÃ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 10400 Three Doctors Road 20754 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examinar once. Black, White, etc. 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Goode Grant H. Watkins Margaret 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10400 Three Doctors Road Dunkirk, Maryland Grant H. Watkins / Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. Comfort Cemetery 08/18/2007 Alexandria, Virginia 4 □ Donation _5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. art1. Ez er the disease, or amplications the shock, wheart failure. List only one cause of a wed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ntra-cranial hour /Medical Due to (or as a consequence of): **Examiner** etastatic Sequentially list conditions, ir any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician the for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∏ Yes 2 1 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation (Month, Day Year) 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 8/15/2007 ø 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Vemula 6, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28240 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Louise D. Winkler-Bailey 2007  $\infty$ /Medical August 14, 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Prince George's Hospital Center Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Months Days Hours Min. October 23, 1939 67 578-52-1167 Director South Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at D.C. Director 1 √yes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5114 Southern Avenue, S.E. 20019 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify þ Black. 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy riqury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) **Direstic Engineer** Housekeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nathaniel Bonds Mamie Williams ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5114 Southern Avenue, S.E. Washington, D.C. Lena D. Winkler (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National Mam. Park August 18, 2007 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4 weeks /Medical Due to (or as a consequence of): **Examiner** Chronic Renal Failure 1 year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit Peripheral Vascular Disease 20 years Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Respiratory Failure 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension autopsy performed 25. Was case referred to medical examiner? 2 X No Be 26. Place of Death (Check only one) 은 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔯 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 XNatural 5 Pending investigation М 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I 29b. Signature and title 29c. License number D16273MD 29d. Date signed (Month, Day, Year)

NA

DHMH 17 Rev 1/2001

State Registrar Revathy Murthy, MD 31. Date filed (Month, Day, Year) AUG 1 7 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature book

**ORIGINAL** 

6130 Landover Road Cheverly, Maryland 20785

8/15/07

Coh	Hui Yun		State of Maryland / Department of Health and Mental Hygier  1- For State Certificate of Death	Reg. No.	200	7 2824							
Med	Physicia dical Exami		Mo	ate of Death	Year	3. Time of Death 1515 hrs							
-			4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	gust 13, 200	c. County of Death	10101113							
			11215 Oak Leak Drive #1906 Silver Spring		Montgomery								
	Funeral	П	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. D										
	Director		220-23-8527   x M 2 F   62 Yrs.   Months   Days   Hours   Min.   2	2/16/19	945 Coi	n.Korea							
	á	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits							
	land f show any		MD Montgomery Rockville	11 11		1 Yes 2 XNo							
	faryland 28a-f shor at once,	Director	10e. Street and Number 10f. Zip Code	10g. Citi	izen of What Coun								
	more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f shown other transmatic event, the Medical Examiner must be notified at once			Kc	orea								
	h with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify V		14. Race - Americ White, etc.	can Indian, Black,							
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	ore, ME es 1 and 2 s of Health ar If item 27 her traums	ı	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date		Location - City or								
	Pages lent of int: I		1 XBurial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:  8/16/	/2007 \$	Silver	Spring,Md							
	Baltimore, permit. Pages I an Department of Her Important: If ite		21. Signature of Funeral Service Licensee PHTH and Address of Facility ALDI E	FUNERAI	L SERVI	CE,P.A.							
			19241 Columbia Blvd	d.Silve	er Sprin	ng,Md20910							
	Physician / Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respitations. List only one cause on each line.	iratory arrest, sh	ock, or heart ·	Approximate Interval Between Onset and							
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7	OX 6876 eath certificate attending phy for use as the	N/u	FFEMALE: 23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   1 Live birth   2 Fetal death   3 Ectopic pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outco	23	Bd. Date of delivery  Month  I	/ Day Year							
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	ords, F w requires is been sign should be	Completed		24a. Was an		topsy findings available							
	e law re has be 2 sh	g E		autopsy performed?	death?	completion of cause of							
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	n of ding Phy After the	일	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. 1 Natural 5 Panelins FOUND: FOUND: 1 Yes 2 W No. Subj.	Describe how in									
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	Division of Vital Records, spinial or Attending Physician: The law require hours after death.  Ineral Director: After this certificate has been siy filled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. L			ral Route Number, City							
	Ospital ospital hours a ineral!			Homicide determined (Specify) Multi-Family Apt. 11215 Oak Leak Drive #1906, Silver Spring, MD									
	Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to one) Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time.										
	To wit	Mec	and manner stated.  29b. Signature and title of certifier  29c. License number		. Date signed (Moi								
	1	gust 14, 2007											
	O.		30. Name and address of person who completed cause of death (Item 23a)										
			Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201										
	St Regist	ate trar											
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 8/13/2007 James Curtis Young Jr. 8:15ath /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Mandrin Hospice House Harwood Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours **X**M 2□ F 68 249-54-1052 12/22/1938 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show notified at MD Anne Arundel Crofton 1 ☐ Yes 2x No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 1610 Kent Fort Lane 21114 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite MXYes 2□No 1956-1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 Black 1 ☐ Yes XXNo Specify: Completed by 3€Widowed 4 □ Divorced 1978 Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Communications Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James C. Young Ermyntrude Graham ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin M. Young 1610 Kent Fort Lane Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot Metro Crematory 8/16/2007 Baltimore, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** metastatio resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an ate has b autopsy performed? Yes 2 No certificate 2 No director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural

Division or Vital Records, P.O. Box 68760, death. ō Hospital

Certification: To 5 Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director;
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie. 29d. Date signed (Month, Day, Year) D 60203 osalyn August usy end mo 15: 2007 30. Name and address of person v no completed cause of death (Item 23a) (Type, Print) Mary land Rosalyin Johns Hopkins CRBI-186 1650 Orleans Street

State Registrar

31. Date filed (Month, Day, Ya

AUG 1 7 2007

DHMH 17 Rev 1/2001

Baltimore

21231

Amend 23a, Partl, LineB, per phys., DOR, 8/17/07, LDB Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 12:01 PM erman August una 10,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, r Location of Death 4c. County of Death Examiner Ber 1: tlantic HOSP:ta General Worcester II Under 24 Hrs. 8. Date of Birth (North, Day, Year) 9. Birthplace (State or Foreign Country) NOV. 30, 1944 Mary/and Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex If Under 1 Year 1 M 2 □ F 214-42-960' Usual Residence of Decedent Months Days Hours Min 62 Yrs. Director 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other treumatic event, the Medical Examinar invalles inclined at 1 Yes 2 No Completed by Funeral Director Talbot Koyal 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 6921 SA 1662 OKins U Neck 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20 No Specify 3 ☐ Widowed 4 ☑ Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) filed withi Hygiane. College (1-4or 5+) Agriculture Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be Beatrice Herman 9 Mathews Young and 19a. Informant's Name/Relationship (Type, Print) 19b. Maili Maddress (Street and Number or Rural Route Number, City or Town, Street Zip Code) Patamoke item 27 Cambridge Way 19e MD 3/6/3 2 Lection - City or Town, State navles oung 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition J 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date Pages nent of Pant: If ite permit. Pages Department of Important: If it any Injury or o Mid Shove Crenation 4 ☐ Donation 5 ☐ Other (Specify) 8/16/07 Cambridge, MD 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Henry Fune Rail Home, F. A.

Henry Fune Rail Home, F. A.

13. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (First) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due Examiner **ENDOCARDITIS** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence Examine the attending physician and ched for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 DNo 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery The law requires that the death 3 Ectopic pregnancy sete hes been signed by the atte page 2 should be detached for 2 | Fetal death Month Day Year 4☐ Pregnant at time of death 5 Other (specify)  $D \circ C = 1/2_{\delta}/7^{\frac{1}{2}} + 4 + D \circ D$ Division of Vital Records, P.O. 9□ Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 4 JUnknown Completed 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No After this certificete 1 ☐ Yes Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 1 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No М the chi within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier License number 29d. Date signed (Morfith, Day, Year) person who completed cause of death (Item 23a) Fyp. Print) 32. F strar's Signature State Registrar

YREMUN YOUN

			Í	For State of Maryland / Department of Health and W		eg. No.	
		Physici	an	1. Decedent's Name (First, Middle, Last)  Betty Lou Allen	2. Date of Deat Month	Day Year	3. Time of Death
	*	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	September 2, 200 4c. County of De		
		Examin	eı	Harford Memorial Hospital Havre De Grace		Harford	
	ı	Funeral Director		5. Social Security Number 16. Sex 1 - Age (In yrs. last birthday) 1 - Inder 1 Year 1 - Inder 24 Hrs. 165-26-7302 1 - M 2 XF 74 Yrs. Months Days Hours Min.		thplace (State or Foreign ountry) nnsylvania	
		land		Usuet Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
		a-f sh	tor	Maryland Cecil Colora		1 ☐ Yes 2 ☐ No	
		th with the 23a or 28 1st be not	ai Dire	10e. Street and Number 25 Wendys Court  10f. Zip Code 21917	Og. Citizen of What C	ountry?	
E	21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher then "natural", or items 23a or 28a-f show sht, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto It Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Specify: User, Specify: User)  14. Was Decedent Ever in U.S. Armed Forces?  15. Was Decedent Ever in U.S. If Yes, specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specify: User, Specif	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	te, etc.
WW.	5-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ang	16b. Kind of Busines:	/Industry
00	121	within iene. than	јдшо	Elementary/Secondary (0·12) College (1-4or 5+)  10  College (1-4or 5+) Housewife		Own Home	
H	Maryland 2	ld be filed ental Hygie ked other ic event, II	To Be Co			Maiden Surname)	
	ary	jes 1 end 2 should be of Health and Mental of Health and Mental If item 27 is marked or other traumatic even	_	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run			
0		of Health item 27		Carolyn Waggoner - Daughter 25 Wendys Court C		laryland 2°	100
10	nor	Peges 1 on the neut of He neut of He nut: If item		20a. Method of Disposition  1 Seurial 2 Cremation 3 Removal from State  4 Operation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Holly Hill Mem Garden 09/			
912107	Baltimore,	permil. Peges Department of Important: If if any injury or o		21. Significant of Funeral Sovice Licenses  22. Name and Address of Facility Br 1407 Old Eastern A	uzdzinsk	i Funeral	Home P.A.
		Physician		23a. Part E fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, o heart failure. List only one gause on each time.  Immediate Cause (Final disease or condition a. — DEUMON I TS	or respiratory arr	est,	Approximate Interval Between Onset and Death
408 302	68760,	The law requires that the death certificate be execded as the law requires that the death certificate be execded as the law red and law red as the burial-transit of certification.	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			,
H 800	O. Box (	it the death certific by the ettending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of d Month	elivery Day Year
200	S, P.	es that the igned by be detact	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
2	ecords	v require been sig should b		Hypertension Coroning artenjoisease,	1 🗆 Yı		Probably 4 Unknown
7	Rec		Completed	Hyperlipidenlia	24a. Was a autops perform	an 24b. Were a prior to death? 2 No 1 \( \text{Ye} \)	
3	Vital	ician: Th certificete rector, pag	Be	examiner?	th (Check only or		
-	ō	ding Physician:  After this certific funeral director,	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 18c. Injury at 18c. Injury 28b. Time of 28c. Injury at 18c.  ence 6 Other (Sp ow injury occurred	ecity)		
ller	Division	teath for: the	Certification:	1 Statural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide building, etc. (Specify)	28f. Location (S. City or Town	treet and Number or I n, State)	Rural Route Number,
J	۵	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	ledicai Cer	29a. Certifier (Check only)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	, and due to the c	ause(s) and manner	as stated.
		o the trithin 24 o the F	Medi	one) and manner stated.  29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo.	
		F 3 F 8		MMMA 17069		Splenher	3. 2007
	(	20		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1 1	110 7 /	7/1-2
		Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature	emood	MY 210	40

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend itematically after the control of the literature of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the cont Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 8/30/2007 10:58 am Leslie O. Andersen 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 2/13/1930 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number 77 577-46-4978 1 □ M 2X XF Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11704 Orebaugh Ave. 20902 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify white Specify: 3 Vidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrator Financing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Ontrich Neva Edmiston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Adrienne Andersen/daughter 1434 Santa Monica Blvd.Santa Monica,CA 90404 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory 9-5-2007 Beltsville,MD 22. Name and Address of Facility 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Silver Spring,MD Rapp Funeral & Crem. Svc. 933 Gist Av. 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ischemic Limb 5 days Due to (or as a consequence of): Thromboembolism 15 days Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): unknown Peripheral Vascular Disease Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ∏Yes 2 ∏No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

/Medical Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

attending physician and for use as the burial-tran signed by the a To the Hospital or Attending Physician: this After Director: within 24 hours at To the Funeral E completely filled it

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed

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Certification: To

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permit. Pages 1
Department of H
Important: If ite
any Injury or ot

**Physician** 

Baltimore, Maryland 21215-0036

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CREST Hypertension 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

D37891

August 30, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. Rajuanshi, M.D. 121 Congressional Ln. #409 Rockville, MD 20852

State Registrar 07-06654 Wasel G Al Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

sel G Ali	1 E	or State	Sta	ate of	Maryland	Depart / <i>Certit</i>	ment of ficate of	f Health a f Death	nd Menta	ıı Hygieni	Reg. No	. <i>(</i>	200	7 28	324
Physician/	Reg	istrar Decedent's Name	e (First, Middl	e,Last)						2. Date Mont	of Death h Day	Year		ime of Death 800 hrs	
'Examiner	TA	2501			G:	ihad		Ab. City, Town,	i and the second		Day JSt 27, 20	07 4c. County o			_
	4a.	Facility Name (i	if not institution	n, give s Drive /	reet and number) on path behi	) nd bldg.		Columbia				Howard			1344
E	5.5	Social Security		6. Sex	7. Ag	ge (In yrs. last	t birthday)	If Under 1 Y			te of Birth(Mi	M/DD/YYYY)	i Foreign		
Funeral Director	l	212-43-		1 ¥ N	2 F	19	Yr		ays Hours	Min. 03	16	88	Country	) Sudai	<u> </u>
	Us	ual Residence o	f Decedent	71		10c. City, T		ation					100	d. Inside City Li	imits
w any	10	a. State	10b. County	**	500.00	Toc. City, 1		umbia					1	Yes 2X	No
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death with the Maryland or items 23a or 28a-f sho must be notified at once.	11	. Marital Status			12. Was Deceder Armed Forces	nt Ever in U.S	i. 13. W	/as Decedent of Yes, specify Cu	Hispanic Origii ban, Mexican,	n? ( Specify Your Puerto Rican,	es or No- etc.)	14. Race White	e, etc.	Indian, Black,	-
or items 23s must be not	1	X Never Marr		Married	postering	2X No	1	Yes 2X	No specify:			Specify:	Bla	ick	=
S mer afte	3	Widowed			or Dates: / highest grade co	ompleted)	16a Decede	ent's Usual Occ most of working	ination (Give k	and of work do	ne 16	b. Kind of Bu	isiness/Indu	stry	
5-0036 ed within 72 hours lygiene. other than "nature he M dical Example Commission	} }	Elementary/Sec			College (1-4 o					asc rolling,		POLIN.			
5-0036 iled within 7 Hygiene. 1 other than the Medica		12th g	rade		lyr		S	ales A	SSO. 18.Mother's	s Name (First,	Middle, Maid	Banan den Surname	<u>a Ker</u>	public	
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nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after nt of Health and Martal Hygiera. tt. If item 27 is marked other than "natural", other traumatic event, the Medical Examinor.	2 1	G <b>ihad</b> 9a. Informant's N	A L 1 Name/Relation	nship (Ty	pe, Print )		19b. <b>Ma</b> il	ling Address (	Street and Num	ber or Rural R	oute Numbe	r, City or To	wn, State, Zi	p Code) vid 210	145
MD 2 d 2 shou lith and M n 27 is n aumatic		Gihad		ath	er	20h F	886	9 Warm	Grand	ite Dr	2	Oc. Location	- City or To	wn, State	-30
re, land f. Heal	2	0a. Method of D	isposition Cremati	on 3	Removal from	Ctoto C	rematory or	other place)		0/21/	/07	Dand	alls	town,	Md
Page ment o	ш.	Donation	5 Other	Special		Kir	22	morial 2. Name and Ad	dress of Facility	V	07	Rand	arro.		====
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Montal Hygiene. Important: If item 27 is marked other thingury or other transmitteevent, the Med.	1	1. Signature of I		1 .1	, ;	2	M	arch	/H wes	SL	Balti	more,	Md	21215 Approximate li	nterval
୍ୟ ଅhysician	2	20 Port I Enter	r the disease, only one cau	or comp	ications that caus	sed the death.	. Do not ente	er the mode of o	ying, suich as c	cardiac or resp	iratory arrest	t, shock, or n	еап	Between Ons Death	et and
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ox 6 ath cer attendi	sicis	1 Yes 2		Unknow		nt at time of d	eath 5	Other (Special	y)						11/
of Vital Records, P.O. Box 68760 ing Physician: The law requires that the death certificate.  After this certificate has been signed by the attending physimmeral director, page 2 should be detached for use as the binneral director,	됩	Part II. Other s		nditions			resulting in	the underlying o	ause given in F	Part I.				he cause of de ably 4 Un	
Division of Vital Records, P.O. tall or Attending Physician: The law requires that the sa der death.  "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.										//	24a. Was a		b. Were aut	topsy findings	available
rds, requir	ete										autops perform	sy	prior to co death?	ompletion of ca	ause of
eco he law ate has	Completed									u. (Ob l. a al.	1 Yes 2	No	1 🗸 Ye	s 2	No
al R ian: T certific	Be	25. Was case r examiner?		dical	Hospital:	patient 2	ER/Outpa		6.Place of Deat Other			Residence	6 🗸 Other	: Scene	
F Vit	၉	1 ✓ Yes 27. Manner of							8c. Injury at Wo	ork? 28	d. Describe h bject assa	now injury oc	curred		
n of ding l h. Afte e funer	ion:	1 Natura	5	Pending	28a. Date of FOUND: tion Aug 27, 2	2007	FOUNE 1800 hr	rs	1 Yes 2	V No				15 / No.	-b City
isio Atter er deat rector by th	ficat	2 Accide 3 Suicide		Investiga Could no	28e Place	of Injury - At	home, farm,	, street, factory,	office building,	, etc. 28	f. Location (S or Town, S 290 <b>Gree</b> n	Street and No state)	umber or Ru	iral Route Num	iber, City
Division of Vital I Bivisial or Attending Physician: hours after death. meral Director: After this certifi y filled in by the funeral director.	Certification:	4 V Homic		determin	ed (Specify)	Woods			i data and			-			
Hos 24 h Fur tely		29a. Certifier (Check only one)	Certifying Medical	ng Physi Examin	cian: To the best	of examination	edge, death n and/or inve	occurred at the estigation, in my	opinion, death	occurred at th	e time, date				
To the within To the comple	Medical	29b. Signature	. [*]	ertifier	and manner st	tated			. License numb			29d. Date	signed (Mo	onth, Day, Year,	)
		$\alpha$	meLa	2 `					O.C.M.E.			August	28, 2007		
115				erson wh	o completed caus	se of death (It	em 23a)	enn Street, E	Baltimore. M	/ID 21201					
7		Ana Ru			ant Medical E	xaminer									
S Regis	tate trai		(Month, Day,	) () 5		Broice.	15	poste							
DHMH 17 Rev 1/2			6,41		AND THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPER		ORIC	GINAL							

DHMH 17 Rev 1/2001

Registrar

Auburger

Robert

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** William Darnes ZOOT M A ua /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 68 MD 219-34-1538 Mar 10 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Sykesville 1 ☐ Yes 2 ▼ No MD Carroll ns 23a or 28a-f sh must be notified Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21784 6520 Carroll Highlands Road Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No 1961— If Xes, Give Year or Dates: 1967 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white Completed by 3 ☐ Widowed 4 🌠 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Medical (Give kind of work done during most of working life. DO NOT use retired) d other than " Elementary/Secondary (0-12) College (1-4or 5+) automotive master auto mechanic 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and 2 should be ealth and Mental Helen Marie Stack is marked Carroll Hanson Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health sitem 27 is Charles Barnes (brother) P.O. Box 153, Manchester, MD 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite 5 1 N Burial 2 □ Cremation 3 □ Removal from State Evergreen Memorial 9-6-07 Finksburg, MD injury 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Daignofaight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 36 hours **Physician** Cardiogenic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Coronary Artery MKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f a∏tJnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 12 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has 1∐ Yes this certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No P 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? I or Attending Patter death. Certification: 1. Natural 5 ☐ Pending investigation To the Hospin...
within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide tacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AT 243 8946-HZ | Aug 31,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew D.O. Union Memorial

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

**OŘIGINAL** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 31, 2007 6:30 PM Leonard Robert Berman August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 3**111** Wheaton Way Apt. C Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1**X**M 2□F 61 Director 014-34-7478 Jan 25, 1946 Massachusetts Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 💢 No Directo Maryland Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? 3111 Wheaton Way Apt. C 21043 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event. Controller Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ Jacob Berman Sylvia Mazer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Alecia Berman - Dry, Daughter</u> 3714 Bonny Bridge Place Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 09/01/07 Baltimore, Maryland 21. Signature of Funeral Service Librase
Thomas Gregor ^{22 Name and Address of Facility} Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 25 Years Immediate Cause (Final Physician Chronic Alcoholism disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine e Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death. e Funeral Director: After this certificate has been signed by the attending physician and attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Essential Hypertension 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ☐ Yes 2□ No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2 To the 29c. License number

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP 0 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

D56531

MID

Harry Li 8600 Snowden River Pkwy, Suite 301 Columbia, Maryland

2. Registrar's Signature

29d. Date signed (Month, Day, Year)

September 1, 2007

21045

State of Maryland / Department of Health and Mental Hygiene a a -

_. Physici	an	1 - State Registrar  1. Decedent's Name (First, Middle, Last)  JAMES	BANKS	Ue.	lilicale	of Death	_ N	Pate of Death Month	b Day	Year 2.007	3. Time of Death 4:21 P M				
/Medi Examir		4a. Facility Name (If not institution, give street and number)  HARBOR HOSPITAL				wn, or Location of I	Death	V/A							
Funeral Director		5. Social Security Number 6. Sex $218-46-8755$ $^{1\square}$ $^{\text{M}}$ 2	7. Age (In yrs. I	last birthday) Yrs.	If Under 1		Hrs. 8. D Min. (/	ate of Birth Month, Day,	Year) <b>2, 1948</b>		place (State or Foreign ntry) Maryland				
ind Z. I. I. 2. 20030 be filed within 72 hours after death valual Hygienes 134 d other than "natural", or items 23a veent, the Medical Examiner must	Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  N/A	10c. City	y, Town or Lo		Baltimore					1 Od. Inside City Limits 1 □ Xes 2 □ No				
	Completed by Funeral Dir	1 Never Married 2 Married 1 If 1 If 2 Newer Married 2 Married 1 If 2 Newer Married 3 Midowed 4 Divorced Yes Cooperity only highest grade composition (Specify only highest grade composition) Elementary/Secondary (0-12)	as Decedent Ever in U. med Forces? Yes 2 No rex Give ar or Dates:  bleted)	16a. Dece	21229  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert  1 □ Yes 2 □ No Specify:  eccedent's Usual Occupation live kind of work done during most of work fe. DO NOT use retired)  Landscaper			Specify Yes or No- rto Rican, etc.)		U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: Black Kind of Business/Industry  Landscape Business					
	Be	17. Father's Name (First, Middle, Last)	_			18. Mother's	s Name (Firs		Maiden Surn		ce - American Indian, ack, White, etc.  fy: Black Business/Industry  Indicape Business  In State, Zip Code)  99  - City or Town, State  Dwings Mills, Md.  17  Approximate Interval Between Onset and Death				
	2	James Ban  19a, Informant's Name/Relationship (Type, Pr		10h Maili	na Address /	Street and Number	or Rural Ro		City or Toy		n Code)				
			un)						-		Code)				
		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State													
Physician /Medical Examiner	iner	Immediat Cause (Final disease or condition resulting in death)  Sequentially list conditions  b.	s that caused the death se on each line.  Ano XiC  Due to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence	Encuence of):		ordying, such as ca	ardiac or res	piratory arre	est,		Interval Between				
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To the Hospital or Attendia within 24 hours ar er deafn. To the Funeral Director: A completely filled in by the it.	Certification:	3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 28f. Local determined 2						ocation (Street and Number or Rural Route Number, City or Town, State)							
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To ti withi To ti	M	29b. Signature and title of certifier	DOCTOR	र		License number				gned (Month	, Day, Year)				
		30. Name and address of person who comple	ed cause of death (Iten		Print)	ol South lan	anover	street	Balti	more 1	ND 21225				
St Regist	ate	31. Date filed (Month, Day, Year) SEP 0 5 2007	32. Registrar's Signa	ature	~ 6° 0				1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amenstate of Mary lend / Depart Henter realities 873 Mental 1979 18 19 7 For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Aug 31, 3. Time of Death ^{Day} 2007 Year 11:45^A **Physician** Jean Gordon Traband Beall Aüg /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Wicom; Worcester Atlantic General Hospital Berlin If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 6, 15 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** 1 M & TYF 214 12 7800 Director 88 Yrs Washington Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Worcester Maryland Wicomi 1 ☐ Yes 2 ☑ No Director Ocean Pines 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5 2 Alexandria Court 21811 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ∏Yes 2∭X√lo If Yes, Give Year or Dates: 1□ Yes 2□ No þ Specify: 3 X Widowed 4 □ Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Store & Deli Liquor 12 Business Owner  $\frac{O8}{8}/3$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental Charles Traband Ida Mae Gordon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20634 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health ar Important: if Item 27 is any injury or other treu once. Sharon Bouchard (Granddaughter) 22445 Greenview Pky, Great Mills, MD Baltimore, 20a. Method of Disposition
20 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept6, Date 2007 20c. Location - City or Town, State Resurrection Clinton, MD Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Consee Alexandria Ferry Road, Clinton, MD 20735 20005 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause in each line. mide of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires thet the death certificate be executed Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown signed by the atte Month Day Year 4 Pregnant at time of death 5 Other (specify) o 9☐ Unknown Part J. Other significant conditions contributing to death but not jestilying in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Vital 1 Yes 2[ : After this certifications a funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only on Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA ð 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation s after de. •al Director: An-1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a
To the Funeral C
completely filled i Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Exeminer: the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated.

State Registrar

0

29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day, Year)

0

0013

d

Jean

completed cause of death (Item 26a) (Type, Print)

32. Registrar's Signature

2007

29c. License number

29d. Date signed (Month, Day, Year)

07-06622 John Paul Blanchard Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 28252

		- For State tegistrar	Ce	ertificate d	of Death		R	eg. No.	001 202	J		
Physicia	sician/ 1. Decedent's Name (First, Middle,Last)							2. Date of Death Month Day Year Average 36, 2007  3. Time of Death 1321 hrs				
ledical Examin			John Paul Blanchard						August 20, 2007			
		4a. Facility Name (if not institution, g 3327 Carroll Avenue	ve street and number)		4b. City, Town, or Owings Mills			4c. County of Death Baltimore County				
Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs	. last birthday)	If Under 1 Year Months Days		A.Co.	` 1i	Birthplace (State or Foreign			
Director	047-28-2943   1X M 2 F   70 Yrs.						Feb.	18,1937	Country) WV	-		
1,000 to 100 to		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Loc	ation				10d. Inside City Limits	7		
<u> </u>	.	MD Bai	Ltimore	Owi	ngs Mills	5			1 Yes 2X No			
Aaryland 28a-f show 1 at once.	황	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?	7		
th the Maryland 23a or 28a-f sho notified at once.	Director	3327 Carroll Av	7 <del>C</del>		2111	7	1 724	U.S	. Δ .	ı		
with the s 23a s 23a e noti		11. Marital Status	12. Was Decedent Ever in	Ü.S. 13. V	Vas Decedent of His	panic Origin	n? (Specify Yes or N	o- 14. Race -	American Indian, Black,	+		
eath r	Funeral	1 X Never Married 2 Marrie	Armed Forces?		Yes, specify Cuban	n, <b>M</b> exican, F	Puerto Rican, etc.)	White,	,	1		
ifter d	by F	3 Widowed 4 Divorce		Yes 2 X No	specify:		Specify:	White				
lours a		15. Decedent's Education (Specify			ent's Usual Occupat most of working life			16b. Kind of Busi	ness/Industry			
6 1.72 h 1.72 h 1.72 h ical E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)					G		h		
003 withi giene.	Ē.	17. Father's Name (First, Middle, La	1	Dial	tsman	18 Mother's	Name (First, Middle		ruction	$\dashv$		
七 年 声 3 5	اه	Louis Blanchar				70.000	Hilda Sch			1		
212 212 Ment Mark	To B	19a. Informant's Name/Relationship		19b. Mail	ing Address (Stree	et and Numb	er or Rural Route Nu		, State, Zip Code)	1		
and 2 should fealth and Note 27 is not traumatic		Helen A. Price	' '				lace Colu					
Te, I		20a. Method of Disposition  1 Burial 2 X Cremation		o. Place of Disp crematory or	osition (Name of cer other place)	metery,	Date	20c. Location - 0	City or Town, State			
More Pages 1 ent of H int: If it		4 Donation 5 Other Special	1 1	-	rematory		8-29-2007	Catonsv:	ille, MD			
Baltimore, permit. Pages I ar Department of He Important: If ite	1	21. Signature of Funera Service Lic		22	. Name and Address	s of Facility	Witzke Fi	ineral Hor	mes, Inc.	٦		
<b>™</b> §9 III	b	Trigetteu	lm-				s Road Ca			4		
Physician ical		23a. Part I. Exter the disease, or cor failure. List only one cause on	each line.				rdiac or respiratory a	rrest, snock, or near	Between Onset and Death			
xaminer		Immediate Cause (Final disease or condition resulting in death)  Atherosclerotic cardiovascular disease  Due to (or as a consequence of):										
		b										
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause										
	amin	C) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								-		
ruted nd ransit	ŭΙ	events resulting in death). Last	d							_		
760, icate be executed physician and the burial - transit	/Medical	X UNPENDED	#23a,PII,27,pe	rM.g871.	9/7/07 TT							
760, ficate be g physic the burn	Ĭ,	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pr	egnancy				23d. Date of		٦		
68 certifi nding	ian	past 12 months?	1 Live birth Pregnant at time of		Fetal death 3 Other (Specify)	Ectopic	pregnancy	Month	Day Year	- [		
Box 68  te death certifi  the attending hed for use as	Physiciar	1 Yes 2 No 9 Unkno										
O. I. at the d by the staches		Part II. Other significant condition	s contributing to death but no	ot resulting in th	e underlying cause	given in Par			bute to the cause of death?			
ires that the signed by the detached	d by	<u>Castrointestinal</u>	hemorrhage						Probably 4 V Unknown	_		
ords aw requi	Completed							opsy p	Vere autopsy findings available rior to completion of cause of			
eco The law ate has	E							formed? d s 2 ✓ No 1	eath? Yes 2 No			
tal Recionaria The lactificate lactor, page	BeC	25. Was case referred to medical			26.Plac	T2 .	Check only one)			=		
Vita hysici this c	9	examiner?  1  Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpati		Other-4	Nursing Home 5	Residence 6	<del></del>	_		
ling Pl	Ë	27. Manner of Death  1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time		ury at Workî Yes 2		e how injury occurre	3G			
Sior Mittend death ctor:	aţi	2 Accident Pending	ation	there form				/Stroot and Number	er or Rural Route Number, Cit	V		
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should I	Certification:	3 Suicide 6 Could r		it nome, iarm, s	treet, ractory, onice	bullarily, etc	or Town		y of Naral Noute Namber, On	'		
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and implietly filled in by the funeral director, page 2 should be detached for use as the burial - trans		29a Certifier	sician: To the best of my know	ledge death or	curred at the time, o	tate and pla	ce, and due to the ca	ause(s) and manner	as stated.			
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	(Check only one) 2 Medical Exami	ner:On the basis of examinatio	n and/or invest	igation, in my opinio	n, death occ	curred at the time, da	te and place, and d	ue to the cause(s)			
To To con	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date signe	ed (Month, Day, Year)	_		
		(alaces)	4/11.		0.0	.M.E.		August 27,	2007			
		30. Name and address of person w	no completed cause of death'(I	tem 23a)						_		
			sistant Medical Examin	er 111 P	enn Street, Ba	Itimore, N	/ID 21201					
St Regist	ate	31. Date filed (Month, Day, Year) SEP 0 5	32. Redistrar's Sign	nature	Buti							
Kedisi	are H		/1(1)   A. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A. C. A	And "								

7. Age (In vrs. last birthday)

10c. City, Town or Location

Manchester

80

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates:

f Under 1 Year If Under 24 Hrs.

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Days

10f. Zip Code

1 ☐ Yes 2X No

21102

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 3altimore, Maryland 21215-0036

**Physician** 

/Medical

**Funeral Director** 

5. Social Security Number

225-28-3834 Usual Residence of Decedent

10e. Street and Number

11. Marital Status

3740 Line Drive

1 ☐ Never Married 2 ☐ Married

3 ☑ Widowed 4 ☐ Divorced

6 Sex

Carrol1

1 □ M 2 😾 F

Examiner

**Funeral** 

Director

**Physician** /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division or Vital Records,

Completed by 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be ್ತಿ Louis Cassidy 19a. Informant's Name/Relationship (Type. Print) Stanley Wurzburger Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 21. Signature of Funeral 23a. Part1. Enter the disc shock, or heart failu Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequent of): Deep Venous thrombosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Completed 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29b. Signature and title of certifier

Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) Pearl Ivy Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3740 Line Drive, Manchester, MD 20c. Location - City or Town, State 9/1/07 Hampstead, MD 22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, MD 21136 Eline Funeral Home complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, boily one cause on each line. Approximate Interval Between Onset and Death embolism

8. Date of Birth (Month, Day, Year)

June 20,1927

10g. Citizen of What Country?

14. Race - American Indian.

White

Black, White, etc.

USA

Specify:

16b. Kind of Business/Industry

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

**ORIGINAL** 

DD060503

29d. Date signed (Month, Day, Year) 18

23d. Date of delivery

Day

Month

Year

а

Birthplace (State or Foreign Country)

VA

10d. Inside City Limits 1 ☐ Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hanover Wampsterd, 31. Date filed (Month, Day, Year)



State Registrar

filled in by

e Funeral F

within 24 ho

To the Function

State of Maryland / Department of Health and Mental Hygien 2007 28254 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 440 **Physician** CZUBACKI 2007 TADEUSZ /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMACE MV 2:

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
09.10.1929 FUTURE CARE HOME WOOD, 2700 N. CHARLE BALTIMORE CITY Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F 218.46.0790 Poland Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1DXes 2 No Baltimore Directo MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with Street 309 E. 33rd. 21218 Poland Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. nd 2 should be filed within 72 hours after the and Mental Hygiene.
27 is marked other then "naturel", or ite; traumatic event, the Madical Expriment. 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Deli Manager Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stefania Duda Bartlomiei Czubacki ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 E. 33rd. St. Baltimore, MD 21218 item 27 Irena Czubacki/wife other Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if its any injury or ot once. 1 Burial 2 remation 3 Removal from State 09.05.07 Beltsville, MD Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation And Funeral Balto Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** acstrointe sturel bleed Laksour /Medical Due to (or as a consequence of) Examiner Veis Manbaces unkrows figure 1 in the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second Dece Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time ot death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobecco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed Hypertusian 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b 24a. Was an Alcehol Abuse 1 Yes 2 No : After this certification funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ Division of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury ne Hoapital or Attending Pl n 24 hours after death. he Funeral Director: After t bletely filled in by the funera 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 1 Alatural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 ş 29b. Signature and title of certifier. 29c. License number 29d. Date signed (Month, Day, Year) DO051056 4/07 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dalject Salvic MT Royal Ave Belt MS 44. 31. Date filed (Month, Day, 32 Registrar's Signature State Registrar

			For State Registrar	State o	f Marylan			f Health and of Death		giene Reg. No 200	7 28255
e.			Decedent's Name (First, Middle	e, Last)					2. Date of Dea	ith	3. Time of Death
77	Physicia			atherine	Ruth	Baxt	er Co	oper	Month 8	Day Yea 31 2007	рм
	/Medic Examin		4a. Facility Name (If not institution			Dane		n, or Location of Dea		4c. County of De	
			Gilchrist (	enter			Тог	son		Balto	
Ь	Funeral		5. Social Security Number 213–36–6972	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.		SON Under 24 Hr	n. (Month, Day	9. B	irthplace (State or Foreign Country)
r	Director		Usual Residence of Decedent	-X	69	115.			12-1	0-1937	S.C.
	land ow st		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Mary Fied	tor	MD	NA	Bai	ltimo	ce				1x∏Yes 2 ☐ No
	th the	Director	10e. Street and Number				10f. Zip Co		-	10g. Citizen of What	Country?
	23a ust b	ral	6204 Gist Av					21215		USA	
	be filed within 72 hours after death with the Maryland ntal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	Armed Fo		.S. 13.	Was Decedent If Yes, specify	of Hispanic Origin? ( Cuban, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Race - An Black, Wi	nerican Indian, nite, etc.
36	s afte	by F	1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv	ve No		1□Yes XX	No Specify:		Specify:	Black
ဝို	hour htural	ed k	15. Deceder	it's Education	ates.	16a. Dece	dent's Usual O	cupation		16b. Kind of Busines	
715	nin 72 i. in "na Medic	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1	1-4or 5+)	(Give	kind of work d DO NOT use r	one during most of w	orking	Baltimo	
212	d with giene er tha	E		6 1703			Educa	tor		Public	
g	be filed v tal Hygie d other i event, th	Be (	12th grade 17. Father's Name ( <i>First, Middle</i> ,	Last)					ame (First, Middle,	Maiden Surname)	
yla	2 should be filed and Mental Hygi Is marked other aumatic event, ti	P.	Artimus Baxt			1		Eliza	beth-Gr	iddle	
Maryland 21215-0036	l 2 sh n and rs m		19a. Informant's Name/Relations				•	reet and Number or I	Rural Route Numbe	r, City or Town, State	,
	is 1 and 2 should of Health and Mer item 27 is marke other traumatic		Candace Bea 20a. Method of Disposition	sley-Dau		l 13	Gwynn sition (Name o	swood Ro	ad Owin	gs Mills	MD 21117 or Town, State
Baltimore,			1 X Burial 2 ☐ Cremation		State	Jennetery, Grei	natory or othe.	place)			
듩	permit. Page Department o Important: If any injury or once.		4 □ Donation 5 □ Other (5	-	_Gā	arrisc	on For	est 9-6	-2007	Owings M	ills, MD
Ba	permit. Departr Importa any inju		1 Xala	Mar	L	-	430	ddress of Facility M O Wabash	arch F/	H West Balto,	MD 21215
			23a. Part1. Enter the disease, o	complications that c	aused the deat	h. Do not ent					Approximate
	Physician		shock, or heart failure. List Immediate Cause (Final		RITONE	AI A	MINER				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		(or as a conseq		INCER				92712
g	Examiner		Sequentially list conditions,	b. ———							
9	D H	iner	cause. Enter Underlying Cause (Disease or injury	Due to	or as a conse	uence of):					
	and trans	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq	mence of):					
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DHMH 17 Rev 1/2001

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State of Maryland Department of Health and Mental Hygiene 2007

	1 - For Stata Ragistrar		pariment of Health and N ertificate of Death	rental Hyglene. Reg. No.	001 20256
Physician /Medical		asi) Laates		2. Date of Death Month Day	Year 2:55 M
Examiner	4a. Facility Name (If not institution, gi	ve street and number)	4b. City, Town, or Location of Death	4c. C	County of Death  Anne Arun due
Funeral Director	213-74-7404	Sex 7. Age (In yrs. last birthda 1 ☐ M 2	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
e Maryland Sa-f show Illied at	Usual Residence of Decedent  10a. State  10b. County  HARYLAND ANNE AR	undel Annapol	4		10d. Inside City Limits 1
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Fages 1 end Pages 1 end ment of Health ant: If Item 21 ury or other 1	SAndra Spliggs - 20a. Method of Disposition  1 □ Burial 2 □ Cremation 3   4 □ Donation 5 □ Other (Spec	Removal from State	ematory or other place)	Date 20c. Loca	ation - City or Town, State
Dalti permit. Departm imports eny inju once.	21. Signature of Funeral Service Lice		22. Name and Address of Facility  Ancy M. CON ! lace f  405 W. Franklin Stream	WHERAL SERVE - BALLWOODE !	
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a	nter the mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between Onset and Death
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o the Hosp thin 24 hou the Fune impletely fill	29a. Certifier (Check only one)  2	nysicien: To the best of my knowledge, dea miner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurred 29c. License number	ed at the time, date and p	ace, and due to the cause(s)
F 3 7 8	- Mi		0006437	- G	isigned (Month, Day, Year)
5	Ja	completed cause of death (Item 23a) (Type	Print) Pd Sufe 300 Am	is an clas	401
State Registrar	31. Date filed (Month, Day, Year) SEP 0 5 20	32/Registrar's Signature	arte		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:00 A M Mae Conner SEP 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ivy Hall Nursing Center Middle River Baltimore If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Pay, Year) DEC 10, 1916 West Virginia 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X** F Days 90 Yrs. 234-22-4664 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show notified at 1 ☐ Yes 2 X No Director MD Baltimore Middle River 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō must be 1300 Windlass Drive 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Examiner 1 ∐Yes 2**X** No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 ☐ Widowed 4 ♥ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than ' Elementary/Secondary (0-12) 9 t h College (1-4or 5+) Presser Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic ever Samue1 Moore Hannah Hunt ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas, daughter 2061 Lynx Run North Port, Florida 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 09/05/07 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. Baltimore,<u> M</u>D 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb 299 Frederick Road Baltimore. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) eare **Physician** /Medical Due for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 

Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 Tes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, P.0. Division or Vital Records,

Hospital or Attending Physician: after death. completely

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 261 S. Highland Avenue Baltimore, MD Irene F. Ibarra, M.D. 31. Date filed (Month, Day, Year) 🗱 Registrar's Signature SEP 0 5 2007

1 Certifying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

2007

SEP 4,

29a, Certifier

(Check only one)

29b. Signature and title of certified

Medical

			Please 1	Type or Print in Black In	ndelible Ink. Ensure h _{::} 8871 9-5-07 wt	All Copies	Are Legible.	
			1 - For State Registrar		ertificate of Death		Reg. No 2007	28258
*	Physic		Decedent's Name (First, Middle, Last,  JACK	R	COMBS	2. Date of De Month 8		3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, give		4b. City, Town, or Location of De		4c. County of Deal	th
	Funeral		5. Social Security Nanty 6. Sec	Medical Century x 7. Age (In yrs. last birthday	SAIIS WILLY  If Under 1 Year If Under 24 H		th 9. Birt	
	Director		558-26- <del>1926</del> 18	M 2□F 81 Yrs.	Months Days Hours Mi	05/27/1	926 Co	hplace (State or Foreign unitry) CA.
	ryland how at		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L				10d. Inside City Limits
	the Ma 28a-f s	Funeral Director	MD WICOMI  10e. Street and Number	CO QUANTIC	0 10f. Zip Code		10g. Citizen of What Co	1 □Yes 2X No
	th with 23a or 1st be	a Di	6115 CATCHPENNY F	ROAD	21856		U.S.A.	
	er dea Items ner mu	inner	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	14. Race - Ame Black, Whit	
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	3 Widowed 4 □ Divorced	1 Y Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:	WHITE
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2	filed within Hygiene. Ither than "	Com	Elementary/Secondary (0-12)	CHIEF			HOTEL	
Maryland	should be fill and Mental H s marked oth umatic even	To Be	17. Father's Name (First, Middle, Last)  ORVIN	COMBS	18. Mother's N MARGAR		, Maiden Surname) WA	GNER
lary	2 shou and M is mar aumat	-	19a. Informant's Name/Relationship (Ty		ling Address (Street and Number or			Zip Code)
	1 and Health tem 27		VIOLET KRICHINSKY/ 20a. Method of Disposition	20b. Place of Disc	OMONA WEST #1 -	BALTIMORE	, MD 21208 20c. Location - City or	Town, State
Baltimore,	Pages nent of I		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	FORBAND		02/2007	BALTIMORE,	MD
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licens		22. Name and Address of Facility 8900 REISTERSTOW			
	<del>ia</del> #		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. Do not en				Approximate Interval Between
	Physician /Medical	9 1	Immediate Cause (Final disease or condition resulting in death)	End Stage R	enal Diseas	se		Onset and Death
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	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of).	04150			
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9289	death certificate be executed e attending physician and of for use as the burial-transit	dical		· Coagulo,	pathy			
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	at the deat by the atti tached for	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Other (specify)		Month	Day Year
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ord	w require been signature should t	eted t	Panereatiti		<u>Lemia</u>	-	Yes 2 No 3 Pr	obably 4 Unknown
or Vital Records,	The law cate has t	Completed	ry per phos,	Phatemia,			psy prior to death?	topsy findings available completion of cause of
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or	Phys this ral dii	은	1 Yes 2 No	lospital: 1 Inpatient 2 ER/Outpatie			dence 6 Other (Spe	cify)
ion	ath. or: After he funera	ation	1. Natural 5 ☐ Pending investigation	(Month, Day Year) Injury	of 28c. Injury at Work?  M 1 Yes 2 No	254, 2550, 55	now injury occurred	
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location ( City or To	Street and Number or Ru wn, State)	ural Route Number,
	lospital hours uneral		29a. Certifier  (Check only 2   Medical Exami	sician: To the best of my knowledge, dea ner: On the basis of examination and/or i	ath occurred at the time, date and pla	ce, and due to the	cause(s) and manner as	s stated.
	To the P within 24 To the F complete	Medical	29b. Signature earlittle or certifier	and manner stated.	29c. License number		29d. Date signed (Mont	
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11	T	(		ompleted cause of death (Item 23a) (Type	_	1-1-	- / . /	20 2/3
V	Sta	ite	STEVEN H	32. Registrar's Signature	. 100 c. carrol	1 St. D	ausoury 11	IN 21804

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiens 1- State Registrar Amend 26, perverbal, 6871, 9/5/07 Ticertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician DASTAGIR-6HULAM SEP 03 20/0 M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD 1+05PITAL COLDMBIA to WARD COUNT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) **№** M 2□ F Months Days Hours Min. Director 74 14 32 Pakistan 212-43-2403 filed within 72 hours after death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any fulury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No **Funeral Director** Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6656 Seneca Drive

11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces? 21046 <u>Pakistan</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Be Completed by Specify: Asian 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 3yrs Elementary/Secondary (0-12) 12th grade Self Employed Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Shair Mohammad <u>Masoom Bebe</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6656 Seneca Drive, Columbia, Md 21046 Naz A. Shakir-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 9/4/07 Randallstown, Md 22. Name and Address of Facility
March F/H West 21. Signature of Fucera) Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 30 4AS Immediate Cause (Final disease or condition resulting in death) PULMONAR FIBROSIS - END STAGE **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a sunscapened off Examiner or Attending Physician; The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed2 1□ Yes 3 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home SEARcsidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3DOA s after death. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier (Check only one) CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00050538 2007. SEPT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIHALICA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP A SPECT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, Month **Physician** 0:30 PM Jurie1 3 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Catonsville Charlestown Care Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🔀 F Months Days Hours New York 067-03-1051 93 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show at 1 ☐ Yes 2 X No a or 28a-f shot be notified a Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with USA ural", or items 23a o il Examiner must be 21228 719 Maidenchoice Lane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Midowed 4 ☐ Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) event, the Medical College (1-4or 5+) Is marked other than Elementary/Secondary (0-12) Healthcare Insurance Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Ellen Sandstrom Frank Ward ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4607 Virginia Drive, Bethlehem, PA 18017 Douglas Donigian - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 9/5/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee H. Williams ²² Name and Address of Facility Cremation Society of Maryland, 299 Frederick Road, Baltimore, 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. arrhythmia Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-transit Exami Anorexia and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical 38 IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown Depression Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Hypertension autopsy performe Cerebra vascular disease certificate To the Hospine. within 24 hours after death.
To the Funeral Director: After this certificate
To the funeral director, par 1□ Yes 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 ☑ Natural 28c. Injury at Work? Certification: 5 Pending investigation (Month, Day Year) Injury 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State

Registrar

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

711 Maiden

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

Choice Lane, Cutonsville, mo 21228

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 U Date of Death Month 1. Decedent's Name (First, Middle, Last) 196-08LEN Augusi 2007 Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Baltanore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 37 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) 1 □ M 2 🕱 F Yrs. MYTANE Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 130 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 31 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: \ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry çondary (0-12) College (1-4or 5+) 14 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiopulnionary Due to (or as a consequence of): 157 minuks CVCIC prematuri Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4□Pregnant at time of death 29 9□Unknown August 2007 9 Unknown

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 is marked other the any linury or other traumatic event, the once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Hygiene. other than "natural", or items 23a or ; ent, the Medical Examiner must be r

Director

Funeral

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Completed

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner

Physician/Medical

Be Completed by

Certification: To

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day,

Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar and attending physician for use as the buria signed by the a d be detached f certificate has been si rector, page 2 should director, within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral (

Division or Vital Records, P.O. Box 68760,

Л	are in Other significant containons c	ontributing to death but not resulting in the underlying cause given in Fatti.	
	Trisomy 21	1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknow	/n
	<u> (arcliac</u> de	FCCF       24a. Was an autopsy performed?       24b. Were autopsy findings available prior to completion of cause of death?         1 □ Yes 2 ⋈ No       1 □ Yes 2 ⋈ No	le
	25. Was case referred to medical	26. Place of Death (Check only one)	
l	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier 1.☆ Certifying Ph (Check only one)	ysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	

29c. License number

29d. Date signed (Month, Day, Year)

29

2007

maust

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Year

05

SEP

Enrigh, MD

ODD North Wolfest. Baltimore, Mid 2128

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death **Physician** Month /Medical (If not institution, give street and number 4c. County of Death, **Examiner** HI Morc 9. Birthplace ler 1 Year ce (State or Foreign **Funeral** 1 2 M 2 □ F Days Hours 7.68.0506 Director itimore Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, 76wn or Location Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Pres 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral d 12. Was Decedent Ever in U.S. Armed Ferces? Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 No US Maryland 21215-0036 Completed by 4 Divorced 16b. Kind of Business/Industry Decedent's Usual Occupation Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 2 should be filed withi and Mental Hygiene. 18. Mother's Name (First, Middle, Mai Be rnant's Name/Relationship (Type. Print) 19b. Mailing Address (Street a Health permit. Pages 1 and Department of Health altimore Place of Disposition (Name of cemetery, crematory or other place) Disposition Location - City or Town, State 1 1 Deurial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Allow Kiher 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final **Physician** anc disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and ched for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. I ☐Yes 2☐No be detached 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 2 No To the Hospital or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

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State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

05

2007

			For State	State of Maryla	•					•	
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	Funeral Director		215-12-9569	Sex 7. Age (In y.	rs. last birthday, Yrs.	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 01/20/	7 Year) 1923	9. Birthpl Count Mary.	ace (State or Foreign ny) Land
	land		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or L	ocation				10	d. Inside City Limits
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy fulury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  XXNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes ※※ No If Yes, Give Year or Dates:	i U.S.   13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes ※ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Specil	ce - America ck, White, e	
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	Sta	ato.	29b. Signature and title of certifier  Sypt  30. Name and address of person who  Shallunma  31. Date filed (Month, Day, Year)  SEP 0 5	32. Registrar's Si	gnature	fact o	· Copo R	-4 20	01761	10	MD 2093
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28264 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2:00A M 2007 mystle DAMME /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 507 Towson 500 Virginia Ave. Apt. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Min Months Days Hours 405.36.1609 Yrs. KY 79 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County rthen "neturel", or iteme 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Completed by Funeral Director OWSON Baltimore 50 10f. Zip Code 10g. Citizen of What Country? 1991114 MYENUE U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Yes, Give 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other then College (1-4or 5+) Elementary/Secondary (0-12) Hospitality Waitress 12 Department of Health and Mental Hyg Important: if Item 27 is marked other any njury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be h and Mental F Pages 1 and 2 should be Lena Sanders Archie Strader 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21286 19a. Informant's Name/Relationship (Type, Print) 500 Virginia Ave. Apt. 507, Towson, MD James Fitzgerald/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 09.05.07 Beltsville, MD Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licensee M01443 mpo Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the sirector, page 2 should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1☐Yes 2☐No 3 Probably 4 □Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 Yes 2 No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 2 🗐 🚜 6 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1. Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident within 24 hours after der To the Funeral Directo completely filled in by th 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide the Hospitai 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bay is of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner is to the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the caus 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ump 30. Name and address of person who compl cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Pegistrar's Signature State 0 5 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 08/26/2007 2:30 PM Michael James Freburger /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 772 203rd Street Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1**X**M 2□F Director 49 09/20/1957 212-70-3637 ME Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 772 203rd Street 21122 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 by Yes 2 □ No 1976 If Yes, Give Year or Dates: 1983 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 22 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Anne Arundel Cty other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Repairman School District 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i Health and Mental I Gerard Freburger Hilda Marrie Farrin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Freburger / Wife 772 203rd Street, Pasadena, MD 21122 permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 08/30/07 | Baltimore, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MEDIZA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown has been si e 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No certificate has irector, page 2 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 25 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural
2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No after death.

Director: / 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funerai 29a. Certifier Curtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check or one) edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature 30. Name and address of

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

5 2007

2. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydienes & O. 7

			For State Registrar	State of Ma	aryianu / Dep <i>Ce</i>	ertificate of L	eaith and i Death		eg. No.	1	28266
	160		Decedent's Name (First, Middle)	e, Last)				2. Date of Deat	th	ear (	3. Time of Death
4	Physicia /Medic	12	Joseph	Т.	F	reeman		August	24 200	7	8:00p M
	Examin	er	4a. Facility Name (If not institutio				Location of Death		4c. County of		
<u>ः</u> —-	Funeral	A 0	Future Care 5. Social Security Number	Nursing Hol	me e (In yrs. last birthda)	/) If Under 1 Year	dallsto If Under 24 Hrs.	8. Date of Birth	9	timo 9. Birthplac	ce (State or Foreign
b	Director		215-34-2038 Usual Residence of Decedent	<b>X</b> □M 2□F	70 Yrs.	Months Days	Hours Min.	(Month, Day, 06 07	37	Country,	MD
	yland iow at		10a. State 10b. County		10c. City, Town or I	ocation		_		10d	. Inside City Limits
	a-f sh	ctor	MD	IA	Bal	timore					M∑Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh		?
	s 23a	eral	7403 Allmont	Road 12. Was Decedent	Ever in U.S. 19		L244 ispanic Origin? (Sr	necify Yes or No-	U . S .	A •	Indian,
	fter de r item iner r	Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Mar	Armed Forces?	No lo	I. Was Decedent of Hi If Yes, specify Cuba		o Rican, etc.)	Black,	White, etc	
99	hours after death with the Maryland tural", or items 23a or 28a-f show al Exeminer must be notified at	by	3 ☐ Widowed 4 ☐ Divorced			1 ☐ Yes 2 ☐ No	Specify:		Specify:	Blac	ck
Maryland 21215-0036	be filed within 72 hours after death with the Marylar tal Hygiene.  d other than "natural", or items 23a or 28a-f show other than matural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)	16a. Dec	edent's Usual Occupa re kind of work done of DO NOT use retired	ation during most of work ()	king	16b. Kind of Busi	ness/Indus	stry
12	filed within 72 Hygiene. <b>xther than "na</b> <b>sther the Medic</b>	dwo	7th grade	College (1-4or 5	5+)	Disable	•		Dis	sable	ed
פַ	e filed w al Hygier other th vent, the	BeC	17. Father's Name (First, Middle	, Last)			18. Mother's Nam	ne (First, Middle, I	Maiden Surname)	)	
<u>ya</u>		To E	William W.				Theres	· · · · · · · · · · · · · · · · · · ·			
Mar	12 sho h and 7 is m traum		19a. Informant's Name/Relation			iling Address (Street a					ode) 1244
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Samatha Bari 20a. Method of Disposition		20b. Place of Dis	B Allmont position (Name of rematory or other place	1		20c. Location - C		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		1 Burial 2 Cremation 4 Donation 5 Other (	3 □Removal from State Specify)		Crematory	1	9/31/07	Baltin	nore.	, Md
a	permit. Departrr Importa any Inju		21. Signature of Funeral Service		Adventure inter-	22. Name and Addres	ss of Facility	77 317 31		1	
•	90 E # 9	_/	xamuu	U. Sugivi	\	4300 Wab	ash Ave	, Balt	imore,		21215
		[]	23a. Part1. Enter the disease, c snock, or heart failure. Lis Imprediate Cause (Final	t only one cause on each li	ne.	enter the mode of dyin	ig, such as cardiac	or respiratory arr	est,	lr.	nterval Between Onset and Death
	Physician /Medical	1	di ease or condition esulting in death)	a. Due to (or as	consequence of):	Y					Truv
	Examiner		Sequentially list conditions	b	3%						
	sit sd	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):						
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68760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical E		d							
			IF FEMALE:			77				1	
BO	attend for use	Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death	B Ectopic pregnancy	1		23d. Date Mont		ay Year
Division or Vital Records, P.O. Box	the d	hysid	1 □ Yes 2 ♣ No 9 □ Unknown	9□Unknown							
S, D	es that gned b	by P	Part II. Other significant condit	ions contributing to death b	out not resulting in the	underlying cause give	en in Part I.		bacco use contrib		
ord	require een si	ted						1)200			oly 4 □Unknown
3ec	e law has b je 2 sł	Completed					<del></del>	24a. Was a autop: perfor	sy pri rmed? de	ior to comp eath?	ey findings available pletion of cause of
ā	in: Th ificate or, pag		25. Was case referred to medic	al			26 Place of Des	1  Yes ath (Check only or	2 <b>X</b> No 1L	☐Yes 2	No No
5	ysicia is cert directe	To Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Outpat	ient 3 DOA Oth	or:		lence 6 🗆 Other	r (Specify)	
0 0	ng Ph (fter th Ineral	L:uo	27. Manner of Death 1 Natural 5 □ Pend	28a. Date of Inju	ury 28b. Time ay Year) Injun	y , Wor	k?	28d. Describe h	ow injury occurre	d	
Sio	ttendi death. stor: A the fu	catio	2 Accident inves 3 Suicide 6 Could	inot be 280 Place of in	jury - At home, farm,		Yes 2 □ No	28f Location (S	Street and Number	r or Rural i	Route Number
<u>&gt;</u>	after after I Direct	Certification:	4 ☐ Homicide deter		tc. (Specify)	on out, ractory, onles		City or Tow		•,,,=,=,	,
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use		29a. Certifier (Check only one)	ing Physician: To the best	of examination and/or	eath occurred at the tir investigation, in my c	me, date and place opinion, death occ	e, and due to the durred at the time,	cause(s) and man date and place, a	ner as stat	ted. the cause(s)
	o the ithin 2 o the omple	Medical	29b. Signature and title of certifi	and manner si		29c. Licens	e number		29d. Date signed	(Month, D.	ay, Year)
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2	T		armand addres of perso	n who completed cause of	death (Item 23a) (Typ	29c. Licens  Property  H. La VITT  Joseph	15 B	n I to MIN	21211		
	St	ate	31. Date filed (Month, Day, Yea	r) 32. Regist	rar's Signature	Acad B	, , , , , ,	5177./1/1			
	Regist		SEP	0 5 2007	Capital All	A CONTRACTOR OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF TH					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** OSTER 11 45 PM 7 8 2007 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Levindale Hebrew Geriatric Center & Hospital Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 No. Carolina Director 217-20-4777 87 Apr 2, 1920 Usual Residence of Decedent death with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 TXYes 2 □ No **Baltimore** Director N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 833 West Pratt Street U.S.A. 21201 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. should be filed within 72 hours after und Mental Hygiene. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black ģ 3 ☐Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cleaners Tailor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche Faison Thomas Alderman ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8252 Streamwood Drive Baltimore, Maryland 21208 Julia Anderson Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 ☐Removal from State 09/05/07 Brooklyn Park, Md. Cedar Hill Cemetery & Mausoleum 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice Estep Brothers Funeral Service, P. A. 1300 Futaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** CONGESTIVE HEART disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ARRYTHMIA ARDIAZ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner law requires that the death certificate be executed physician and s the burial-transit OF UNKNOWN HEMATURIA AETIOLOGY that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ HYPERPARA THIROLDISM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate ha Be ٩ Certification:

within 24 hours a

To the Funeral I

completely filled

Comple				24a. Was an autopsy performed?  1 ☐ Yes 2 ☐ No
Be (	25. Was case referred to medical		26. Place of Death	(Check only one)
일	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing Hor	me 5 ☐ Residence 6 ☐ Other (Specify)
	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		et, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
edical (				and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
ž	29h. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

PHYSICIAN

D0064533

29d. Date signed (Month, Day, Year) 29-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE HEBREW GERLATTIC CENTER 2434 W BELVEDERE AVE. BATTIMORE, MD 21215 Mi BABATUNDE AJANI

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 10b ce f per fb 9871 9-5-07 vt
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month P **Physician** FLEISHMAN SARA 01 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 VA 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 M 2 K Months 12/28/1916 90 237-12-7766 Director Usual Residence of Decedent 10b. County **Baltimore**MONT GOMERY 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at Owings Mills 1 ☐ Yes 2 No Directo MD BETHESDA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4730 Atrium Court #267 o e _ 21117 пs 23a must b 6109 MASSACHUSSETTS AVENUE  $\frac{-20816}{}$ USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or iter 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 XWidowed 4 ☐ Divorced er than "natura", the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MENS CLOTHING **BOOKKEEPER** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be item 27 is marked other traumatic ev **ETHEL** ABELKOP STEIN ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6109 MASSACHUSSETTS AVENUE, BETHESDA, MD ILENE JONES / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MTRRO KODESH-BETH ISRAEL CONG. Important: If its any injury or o once. 1 Burial 2 Cremation 3 Removal from State 09/03/2007 BALTIMORE, MD 4 Donation 5 Dother (Specify) SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed ig physician ar as the burial-t Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 2 No 3 Probably 1 ☐ Yes 24a. Was an Were autopsy findings available prior to completion of cause of has e 2 autopsy performed certificate ha death? 1 ☐ Yes 2□No 2 1 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the I 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 144817 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 34 h Schreder am felh wore led 31. Date filed (Month, Day, Year) trar's Signature State 05 2007 Registrar

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			For State	State of M	laryland /			of Health		tal Hygi	ene 2007	28269
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	/Medic		4a. Facility Name (If not institution,	nive street and number		/		own, or Location		igust	31 2007 4c. County of Deal	6:00a
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	Funeral			. Sex 7. A	Age (In yrs. last	birthday)	If Under 1	Year II Unde	r 24 Hrs. 8. D	ate of Birth	9. Birt	hplace (State or Foreign
	Director		218-30-7238	1 X M 2□ F 7	71	Yrs.	Months	Days Hours		Month, Day,		puntry)
	<u>ت</u> ع		Usual Residence of Decedent		10-01-7							Land tracks on their
	aryta	-	MD Carroll		10c. City, To							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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	with the	by Funeral Director	10e. Street and Number	E			10f. Zip C			10	g. Citizen of What Co	ountry ?
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336	al', or	by	3 Widowed 4 Divorced	If Yes, Give X Year or Dates	1		1 ☐ Yes 2	No Specify	<i>/</i> :		Specify: wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23e or 28e-f ahow ha Medical Exertinar must be notified at	Completed	15. Decedent's		16	Sa. Dece	dent's Usual	Occupation done during mo	at of undring	1	6b. Kind of Business	Industry
215	B. "n	ple	(Specify only highest Elementary/Secondary (0-12)	College (1-40)	r 5+)	life.	DO NOT use	retired)	ist of working			
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Maryland	iges 1 and 2 should be filed within 72 hours after death with the Maryiar It of Health and Mental Hygiene. If Item 27 is marked other than "natural", or iteme 23s or 28s-f show or other traumatic event, It a Madical Examinar must be notified at	1	19a. Informant's Name/Relationshi Elizabeth Grenag		. 1						City or Town, State, I	
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Ba	permit. Pages 1 Department of H Important: If Ite any injury or otl ance.		Dauge Haige	1		F	.O. Bo	x 195 S	""'Haight Sykesvil	Funer 1e, M	ral Home & D 21784	
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caus nly one cause on each	ed the death. D	o not en	ter the mode	of dying, such a	s cardiac or res	piratory arre	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_ a	Sep	51	2					7 days
	/Medical Examiner		resulting in death)	Due to (or a	as a consequenc	ce of):	1 5					14 days
		<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	es a consequenc	ee of):	TIS					17 days
	nsit	in in	Cause (Disease or injury	223.5 (3.25	, , , , , , , , , , , , , , , , , , , ,	,-						
<b>–</b>	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or a	as a consequent	ce of):						
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89	certifica nding ph use as th	Med	IF FEMALE:				-					
Вох	death ce e attend ed for us	lan/	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal dea	ath 3[	Ectopic preg				23d. Date of de Month	livery Day Year
o.	0 0 D	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant 9☐Unknown	at time of death	51	Other (spec	city)				•
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Records,	w requires that the s been signed by the should be detache	Completed by	Diabetes							1 🗌 Ye	s 2 No 3 P	robably 4 Durknown
õ		iete	Penaher	1 Vasi	cular	7	0154	DOCP		24a. Was ar	24b. Were at	utopsy findings available
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>	\$ w 5	To B	examiner? 1 ☐ Yes 2 ☐ ¶o	Hospital: 1 🗌 Inpa	tient 2 ☐ ER/	Outpatie	nt 3 DOA	Othor			nce 6 Other (Spe	cify)
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Sio	Attending r death. ector: After by the fune	atic	2 ☐ Accident investiga	tion			М	1 Yes 2	]No			
Division	r Att ter de lrect	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place of I	Injury - At home, etc. (Specify)	, farm, st	reet, lactory,	office		ocation (Str City or Town	eet and Number or R. , State)	ural Route Number,
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	To the To the Comp	Š	29b. Signature and title of certifier					License number			d. Date signed (Mont	
:	d		100				N	0054	337	1	tugust	31,2007
	(0)		30. Name and address of person w	ho completed cause of	f death (Item 23	a) (Type,				, .	2/	31,2007 hd 21797
	*		Kichard G.S	stetanacc.	1 DO 3	252	Star.	ting Gi	nte Ct	Wo	od bine hi	nd 21797
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend 10e, 19b, per FH, 6871, 9/5/07 TT Certificate of Death Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Grimes gust ouisa 2007 /Medical Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner North west Date of Birth (Month, Day, Year) Social Security Number . Age (In yrs. last birthday If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Min. 219-56-6029 Months Davs 1 □ M Director 20 495 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show r 28a-f show notified at Director 1 ☐ Yes 🎗 🖫 No Baltimore Randallstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or dical Examiner must be 3904 Carthage Road 21133 Funeral S Α 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 🛂 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black \$ 3 Widowed 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Beauty Consultant Hecht's permit. Pages 1 and 2 should be filed very permit. Pages 1 and Mental Hygis Important: If Item 27 is marked other any Injury or other traumatic event, #I 12th grade 17. Father's Name (First, Middle, Last) years 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Coates ပ္ Minnie Hawkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Grimes - husband 3904 Cartage Road Randallstown, MD 21133 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-5-2007 Cedar Hill Cem Anne Arundel Co, MD 21. Signature of Funeral Service License 22. Name and Address of Facility March F/H West al 4300 Wabash Avenue Balto, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) arterioselerotic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1☐ Yes 2 No 9☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? be 2**X** No 1 🔲 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 100 ို 1 Inpatient ER/Outpatient 3 DOA funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: / filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manyer stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Do057776 pletec ause of death (Item 23a) (Type, Print) ston

State Registrar 31. Date filed (Month, Day, Year)

SEP

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2007

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32. Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** GRICE 3) 200 AUGUST /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner RANDALLSTOWN NOOK HWELL RALSIMURE 17 05875AZ If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Coyntry) Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🕡 Director 160 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐Yes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 20100 Specify þ 3. Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation marked other than "natu matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Houseu 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be item 27 Is marke other traumatic 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) COUSIN 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 22. Nome and Address of Facility 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying—such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANGERIDSCLERDRIL CAROITVASCULAR Physician /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 25 No Day 4☐Pregnant at time of death 5 Other (specify) the 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 20 1□ Yes completely filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 1 ☐ Yes 2 1 🗌 Inpatient 2 P/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? after death. Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Within 24 hours a To the Funeral L 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ٩ 0024971 31,200 AVGVST

State Registrar

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DHMH 17 Rev 1/2001

**ORIGINAL** 

RIAD

RANDALLSTOWN, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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COVOR 32. Registrar's Signature

5401

FRBER

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Jerry A. Griffin 31,200 tugust /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner HIMORE Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 21, 1962 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 № M 2 🗆 F 212-88-1778 45 Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1XIYes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 457 Oxford Court 21201 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XX No SpecifAfrican American Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Baltimore, Maryland 212 janitor service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Allen Hinton Saundra Griffin ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saundra A. Conley/ Mother P.O.Box 222; Lottsburg, Virginia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State King Memorial Park 09/06/2007 Randallstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical intestinal Bleeding **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Donknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2□No 1□ Yes 1 ☐ Yes 25. Was case referred to medical exampler? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After ospital c. 4 hours after deal. -ral Director: After 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L the Hospital Medical ( Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) land Greneral Hospital

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 28273 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 09/01/2007 7:00 PM Joan Thelma Heffner 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death

7. Age (In yrs. last birthday)

72

10c. City, Town or Location

Pasadena

Annapolis

10f. Zip Code

If Under 1 Year | If Under 24 Hrs.

Anne Arundel

10g. Citizen of What Country?

U.S.A.

Birthplace (State or Foreign Country)

MD

1 ☐ Yes 2 No

10d. Inside City Limits

8. Date of Birth (Month, Day, Year) 11/16/1934

**Funeral** Director

**Physician** 

/Medical

Examiner

Director

Anne Arundel Medical Center

10b. County

6. Sex

Anne Arundel

1 □ M 2 🔀 F

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22. Registrar's Signature

Jacqueline

SEP 0 5 2007

31. Date filed (Month, Day, Year)

5. Social Security Number

MD

10e. Street and Number

216-32-0062 Usual Residence of Decedent

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be n-tiffied at any injury or other traumatic event, the Medical Examiner must be n-tiffied at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

ā	444 Magothy Bridge Road	211	22	U.S.A.	
ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of	Hispanic Origin? (Specify Yes or I ban, Mexican, Puerto Rican, etc.)	No- 14. Race - Am Black, Wh	
F	1 ☐ Never Married 2 Married 1 ☐ Yes 2 No				
by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🗷 No	Specify:	Specify:	White
ted		Decedent's Usual Occu	pation	16b. Kind of Busines	-
ple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retir	during most of working ed)	Balto Ass	sn of
E		Superviso	r	Retarded	Citizens
Ö	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Midd	lle, Maiden Surname)	
To Be Completed by Funeral	Milton G. White		Mary F. The	1ma Myers	
_	19a. Informant's Name/Relationship (Type. Print) 19b.	Mailing Address (Stree	t and Number or Rural Route Nur	nber, City or Town, State,	Zip Code)
			/ Bridge Rd.,	Pasadena	, MD 21122
	20a. Method of Disposition 20b. Place of cemeter	Disposition (Name of y, crematory or other pl	Date	20c. Location - City of	or Town, State
	Partial 2 Cremation 3 Removal from State	iew Mem P	ı	Sykesvi	11e, MD
	21. Signature of Fundal Service Licensee		ess of Facility G.J.Gor	ce Funera	1 Home, PA
	14/9,		era Drive, Pa		
	23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	ot enter the mode of dy	ing, such as cardiac or respiratory	arrest,	Approximate Interval Between
	Immediate Cause (Final	andient	facetion		Onset and Death
	disease or condition resulting in death)  a		(100(0)1111		noung
	DIVE WH	he (mina	sensis		hous
<u>~</u>	Sequentially list conditions, if any leading to immediate b.  Due to (or as a consequence of	of):			10000
nin	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	,			
xan	that initiated events c	of):			
三田	220 10 (01 20 2 0511004281100				
di	d				
Me	IF FEMALE:				
ian/	23b. Was decedent pregnant in the past 32 months? 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death			23d. Date of d Month	elivery Day Year
Sic	in the past N2 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  in the past N2 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (specify)		-	,
Completed by Physician/Medical Examiner		Alba conduction and a	han in Bart 1 020 Di	d tabassa usa santributa	to the equal of death?
ρ	Part II. Other significant conditions contributing to death but not resulting in			d tobacco use contribute	
ed	_ end stage renal duren			_Yes 2 No 3	Probably 4 Unknown
plet			24a. W	as an 24b. Were	autopsy findings available
E			pe 1□ Ye		o completion of cause of ? es 2 □ No
O	25. Was case referred to medical		26. Place of Death (Check on		55 2 110
To Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Nopatient 2 ☐ ER/Out	tpatient 3 DOA	ther: 4 Nursing Home 5 Re		pecify)
Ξ.	27. Manner of Death 28a. Date of Injury 28b. T	ime of 28c. Inj		e how injury occurred	,,,,,,
tio	1 Matural 5 □ Pending (Month, Day Year) In 2 □ Accident investigation		Yes 2 □ No		
fica	3 Suicide 6 Could not be 28e. Place of injury - At home, far	m, street, factory, office		(Street and Number or	Rural Route Number,
erti	4 Homicide determined building, etc. (Specify)		City or	Town, State)	
C	29a. Certifier 1 Certifying Physician: To the best of my knowledge	, death occurred at the	time, date and place, and due to t	he cause(s) and manner	as stated.
Medical Certification:	(Check only 2 Medical Examiner: On the basis of examination an one) and manner stated.				
Me		29c. Lice	nse number	29d. Date signed (Mo	nth, Day, Year)
_	29b. Signature and title of certifier  And prelimed Ran MD	'n	51076	09-04	
	Acres carried 1				0.0- /

State Registrar

Ryan 2001 Medical Parkway Annapolis, md-21401

Box 68760, P.O. Records, or Vital Division To the Hospital o within 24 hours aft To the Funeral Di completely filled in

Baltimore, Maryland 21215-0036

State Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

L.

ARTHUR

AMENDING

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

PUDO

PHYSICIAN

904 WASHINGTON

Roun

29d. Date signed (Month, Day, Year)

WESTMINSTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death sep. 4, 2007 Robert M. Henderson, Sr. 8:15 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Maryland Months | Days Hours 81 Aug. 15,1926 212-22-6741 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes XXNo Finksburg MD Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2505 Arabian Ct. 21048 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No WW II If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married XX Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Plumbing & Elementary/Secondary (0-12) College (1-4or 5+) Master Plumber Heating 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mattye A. Richards Robert Henderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine A. Henderson/Wife 2505 Arabian Ct. Finksburg, MD 21048 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Maryland Veterans 9/11/07 Cemetery XX Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD 4 Donation 5 Dother (Specify) 21. Signature Funeral Service License 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 1m 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MIKE years Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed? 1∏ Yes 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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27 Is marked or traumatic ev

Health tem 27 I

permit. Pages Department of Important: If it any Injury or o once.

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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director funeral

The law requires that the death certificate be executed

Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

attending physician and for use as the burial-transit signed by the at a be detached for certificate has been s irector, page 2 should this After death. within 24 hours after death

To the Funeral Director:
completely filled in by the i

Exam Physician/Medical 2 Completed Be P

State

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Nospiù 1 Yes 2 No 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Hornicide 29a. Certifier TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 51303 allum 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST PORSON MD 21204 GARDA J. CHAMERS WO 6701 N-32. Bigistrar's Signature

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

SEP 0 5 2007

* Marie

			For State of M	aryland		rtment o			al Hygie Reg.	ne No.2007	28276
	Physici		1. Decedent's Name (First, Middle, Last)  Mary J. IJallaway					Mo	te of Death	Day Year	3. Time of Death
•	/Medio Examir Funeral		4a. Facility Name (If not institution, give street and number)  Bultimore Wushing to Medice  5. Social Security Number  7. Ag  7. Ag	je (In yrs. la		Glen If Under 1 Y	BUCTI ear If Unde	of Death	e of Birth	Ac. County of Death	
	Director		216-34-6879 1□ M 2⊠ F Usual Residence of Decedent		70 Yrs.		ays Hours	Jun	e 28	1937	MD
	after death with the Maryland or Items 23a or 28a-f show miner must be notified at	Director	Maryland Anne Arundel  10e. Street and Number	10c. City,	, Town or Lo		adena _{de}		10g.	Citizen of What Cou	10d. Inside City Limits 1 □ Yes 2 ☑ No Intry?
136	172 hours after death with the Marylar "natural", or Items 23a or 28a-f show cdical Examiner must be notified at	by Funeral Director	39 Nicholson Drive  11. Marital Status  1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced  12. Was Decedent Armed Forces 1 □ Yes 2 ☒ If Yes, Give Year or Dates:	•		Was Decedent f Yes, specify		rigin? (Specify Ye an, Puerto Rican,	es or No- etc.)	USA  14. Race - Amer Black, White Specify:	
Hollaway、Mary Baltimore, Maryland 21215-0036	filed within 72 hours Hygiene. other than "natural"; ent, the Medical Exal	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or	5+)	(Give life. L	lent's Usual O kind of work d OO NOT use re chine O	one during mo etired)			T&T Manuf	,
Hollaway.	ild be filed lental Hyg ked other ilc event,	To Be C	17. Father's Name (First, Middle, Last) Edward Mack	,				ner's Name <i>(First,</i> lary	Middle, Mai	*	
11000 Mary	nd 2 should aith and Men 27 Is marke r traumatic		19a. Informant's Name/Relationship (Type. Print) Charles J. Hollaway (spou	se)						ity or Town, State, Z	ip Code)
Ho Itimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical.		20a. Method of Disposition  1 XI Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Ligencee		ace of Dispo emetery, crer eland	sition (Name of matory or other Memoria . Name and A	al Pk.	Sept. (	05 Pa	c. Location - City or T	Maryland_
Ba	permi Depa Impo any Ir		I Jul 2 July	the death		3111 M	ountair	n Road, F	Pasade	Funeral Ho na, MD 21	122
	Physician /Medical Examiner		23a. Part Venter the disease, or complications that cause shock, or heart failure. List only one cause on each i Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as	1001	bstru						Approximate Interval Between Onset and Death
8760,0	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as	а сопъеци	ance oil).	ucn-n	VE   4 f ( =	716			( MUM )
.O. Box 6	The law requires that the death certifics the has been signed by the attending plage 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2 Fetal	death 3 [	]Ectopic pregr ] Other <i>(specil</i>				23d. Date of deli Month	very Day Year
rds, P	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death I acte Yes piratory failure	out not resu	Iting in the u	nderlying caus	e given in Part	1. 23	e. Did tobac	co use contribute to 2□ No 3□ Pro	the cause of death?
Division or Vital Records, P.O		Completed by							la. Was an autopsy performed Yes 2	prior to d	topsy findings available completion of cause of
or Vita	Physiclan this certifi al director	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpati		ER/Outpatier		Other: 4 🗆 N	ce of Death (Chec		e 6 □Other (Spec	eify)
sion o	ding l		27. Manner of Death  1  Natural 5  Pending (Month, Dispension investigation investigation   Constitution   Con	ay Year)	28b. Time o Injury	M	Injury at Work? 1 ☐ Yes 2 [	□No		injury occurred	
Divis	Hospital or Att 24 hours after de Funeral Direct tely filled in by t	Certification:		тс. (Ѕреспу	") 			Ci	ty or Town, S		
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best 2 Medical Examiner: On the basis and manner s	of examinat		vestigation, in	my opinion, d	eath occurred at t	he time, date	and place, and due	to the cause(s)
	with To 1	Σ	29b. Signature and title of certifier  Stuart  Jawk	a M	מ	00	cense number	83	2	aptember	
_	12		30. Name and address of person who completed cause of STUGIT Jacubs mp 30	death (Item کے ل	23a) (Type,	Print) (	3-len P	burnie, r	no al	<i>D6</i> /	
	Sta Regist	rar	31. Date filed (Month, Day, Year) 32 legist SEP 0 5 2007	rar's Signat	ure	esti)		burnie, P		,	

07-06716 Verna Lee Jenkins

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 28277

Terria Ecc Corne		1- For State	Certifi	icate of	Death		Reg	. No.	
Physici		Registrar  1. Decedent's Name (First, Middle,Last)					Date of Death     Month	Day Year	3. Time of Death 1930 hrs
I Exami	ner	Verna Lee Jenk	ins				August 29,	2007 4c. County of De	
		4a. Facility Name (if not institution, give		4	b. City, Town, or Lo Reisterstown		n	Carroll	aui
		southbound Route 91 south		himb day)	If Under 1 Year	If Under 24H	rs 8 Date of Birth	(MM/DD/YYYY) g.	Birthplace (State or
Funeral Director		5. Social Security Number 6. Sex 216-92-2904	7. Age (In yrs. last)	Yrs.	Months Days	Hours M			reign Country) MD
to the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Locatio	on				10d. Inside City Limits
e Maryland or 28a-f show any	5	MD Baltimore							1 Yes 2 Y No
hoursafter death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.	Director	10e. Street and Number 15300 Parrish Roa	ıd		10f. Zip Code 21155			g. Citizen of What C	
th with t	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was	s Decedent of Hisp es, specify Cuban,	anic Origin? ( Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ar White, etc	
er dez , or i	Fu		1 Yes 2 No	1	Yes 2 X No	specify:		Specify:	white
2 hours aft "natural"	1 by	15. Decedent's Education (Specify onl	or Dates:	6a. Deceden	t's Usual Occupation	on (Give kind o	f work done	16b. Kind of Busine	ess/Industry
72 hou	etec	Elementary/Secondary (0-12)	College (1-4 or 5+)		ost of working life.			septic	
036 ithin are.	Completed	11		operat		·			
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	S	17. Father's Name (First, Middle, Last)			1		me (First, Middle, N		
121 121 126 126 120 121 121 121 121 121 121 121 121 121	B	Marvin Andrew Du	cham	10b Mailing	Address (Street	LILL:	ie Bell F	lensley ber, City or Town, S	State, Zip Code)
D 21 should: Ind Mer	2	19a. Informant's Name/Relationship (Ty Curtis Jenkins Jr						MD 21155	
, MD und 2 sho eafth and em 27 is		20a. Method of Disposition	20b. Pla	ce of Dispos	ition (Name of cen	netery,	Date	20c. Location - Cit	y or Town, State
Baltimore, MD 21215-0036 permit Pages I and 2 shout be filed within 72 hoursafter Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		1 Burial 2 X Cremation 3	Removal from State cre	matory or ot	_{herplace)} ty Cremat	ion 9-	5-07	Sykesvil	lle, MD
ti Pag treent treent		4 Donation 5 Other Specify: 21. Signature of Funeral Service License						ral Home	& Chanel
Bal permi Depar Impo	,	Bhean Li Ha	LIC NO0769	P.(	). Box 19	5 Syke	sville. N	ID 21784	Q One per
hysician	-	23a. Part I. Enter the disease, or compl	ications that caused the death. D	o not enter t	he mode of dying,	such as cardia	c or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
Medica	1	failure. List only one cause on ear Immediate Cause (Final disease a	M.l la injustic	es					Death
Examine	7		Due to (or as a consequence of):					W 12	
		Sequentially list conditions, b.	a de la la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya d						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):			100			_
	Xam L	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):						
recuted 1 and 1 ransit									
760, cate be exe physician a	Medical	X UNPENDED	AMENDED 7,28a-f, pe		71 <b>,</b> 9/15/07	TT		23d. Date of de	dison
760, Trate be		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregna		etal death 3	Ectopic pre	gnancy	Month	Day Year
certific	sician/	past 12 months?	4 Pregnant at time of dea	44	ther (Specify)				
Box e death c the atten	hvsi		9 UIKIOWII						ite to the cause of death?
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed retent. retent. After this certificate has been signed by the attending physician and	by P!	Part II. Other significant conditions	contributing to death but not res	sulting in the	underlying cause	given in Part I.			Probably 4 Unknown
ds, equire	Completed					<u> </u>	24a. Was		ere autopsy findings available or to completion of cause of
COT law ra has b							perfe	ormed? dea	ath? ✓ Yes 2 No
Records,  The law requir	[ ]	OF Was are referred to modical			26.Plac	e of Death (Ch		2 10 1	
ital iciam s certi		examiner?	Hospital: 1 Inpatient 2	ER/Outpatier		Other	ursing Home 5	Residence 6	Other: Scene
Division of Vital Recoins after death.  The law after death.  The law is a fire the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a fire to the law is a		27. Manner of Death	28a. Date of Injury	28b. Time of	Injury 28c. Inju	ury at Work?	28d. Describe	how injury occurred was driver	of vehicle/
on on on on on on one on one one one one		1 Natural 5 Pending	(Month, Day, Year) 8/29/2007	7:17 pr	n 1	Yes 2 X No	lvehicle	collision	
isiC Atte er dea	ertificati	2 X Accident Investigat 3 Suicide 6 Could not	28e Place of Injury - At ho			building, etc.	28f. Location	(Street and Number State) S/B RTG	or Rural Route Number, City 91 South OI erstown, MD
Div ital or rat Di	lled ii	Suicide 6 Could not determine	d (Specify) street						
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: v	pletely ti		ian: To the best of my knowledg	je, death occ nd/or investig	urred at the time, of ation, in my opinio	late and place, n, death occur	and due to the cau red at the time, dat	use(s) and manner a e and place, and du	e to the cause(s)
To T	Madical	29b. Signature and title of certifier	and manner stated.			se number		29d. Date signed	(Month, Day, Year)
int	1	MILA	$\langle  \mathcal{V} $		0.0	.M.E.		August 30, 2	2007
of low		30. Name and address of person who	completed cause of death (Item	23a)					
£ .	1	Susan Hogan MD. Ass	istant Medical Examiner	111 Pe	enn Street, Ba	Itimore, MD	21201		
	Stat	e 31. Date filed (Month Day, Year)	32 Registrar's Signatu	to da	2000				

Registrar

07-0 Curti

Examir	-		cedent's Name (First, Midd				of Death		2. Date of Death Month August 29	Day Year	3. Time of Death 1930 hrs
		1- 5	Curtis Dea		Jenkins — Sr	<del>-</del>	4b. City, Town,	or Location of I		4c. County of D	Death
	H	4a. F S	outhbound Rt 91 so	uth of A	Itondale Road		Reistersto		in la puis pie	Carroll	J. Birthplace (State or
neral ector			cial Security Number 4-84-6326	6. Sex	7. Age (In yrs	. last birthda	y) If Under 1 Your Months Do	ear If Under 2 ays Hours	Min. Jan. 5	IF.	oreign Country) MD
м япу.	esprinter distribution	10a.	Residence of Decedent State 10b. County Balt	imore		ity, Town or I	Location				10d. Inside City Limi
23a or 28a-f show a	ţċ	10e.	Street and Number		<u>_</u>		10f. Zip Code	9	1	0g. Citizen of What	Country?
snoot and Memai Hygiene 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Exammer must be notified at once	Director		5300 Parrish	Road	d			155	1 61	USA	American Indian, Black,
ms 23a be.not			Marital Status		12. Was Decedent Ever in Armed Forces?	n U.S. 1	<ol><li>Was Decedent of If Yes, specify Cu</li></ol>	Hispanlc Origin ban, Mexican, I	n? ( Specify Yes or No Puerto Rican, etc.)	White,	
or iten must l	Funeral	,	Never Married 2	- 1	1 Yes 2 X No	0	1 Yes 2X	No specify:		Specify:	white
nher.	by				f Yes, Give Year or Dates: y highest grade completed	1 148 - Da	and antic Heural Occi	nation (Give k	nd of work done	16b. Kind of Busi	
lygiene other thau "natural", the Medical Examiner	Completed		lementary/Secondary (0-1		College (1-4 or 5+)	- 00	ring most of working			septic	,
than edical	nple	]	9			ow	ner of se		Name (First, Middle,	_	
Hygier other			Father's Name (First, Midd		<b>n</b> .c			Doris	Ella Yow	e11	
Mental Hygiene marked other than c event, the Medical	Be		ouis David			19b.	Mailing Address (S	street and Num	ber or Rural Route Nu	mber, City or Town	, State, Zip Code)
and M 7 is m natic	P		urtis Jenkir		(son)	1	5300 Parr	ish Rd.	, Upperco	, MD 2113	City or Town, State
ment of Health and N lant: If item 27 is n or other traumatic		20	Method of Disposition		2	cremator	Disposition (Name or y or other place)		Date		
ent of l		1	X Burial 2 Crema  Donation 5 Other	ion 3	Removal from State	Crest	Lawn Memo		9-7-07		tsville, MD
Department o Important: injury or oth		21	Signature of Funeral Serv	ice Licens	see	-1.11	22. Name and Ad	dress of Facility	Haight Fu	neral Hom	ne & Chapel
			Gran o	(, pt	aught MOO	169	P.O. Box	195 St	kesville,	arrest, shock, or hea	art Approximate Inte
ysiciar		23	<ul> <li>Part I. Enter the disease failure. List only one ca</li> </ul>	use on ea	CIT III IC.		enter the mode of a	<b>,9</b> ,			Between Onset Death
Medica amine	2"	Im	mediate Cause (Final dise condition resulting in deat		Multiple injur  Due to (or as a consequer						
			equentially list conditions,	b.							
	190		any, leading to immediate luse. Enter Underlying Ca		Due to (or as a consequer	nce of):			OT. 0		
scuted and francit	Evaminer	e (E	pisease or injury that initiat vents resulting in death) L	ed .	Due to (or as a conseque	nce of):			V)		
	- ng		X UNPENDED	$\neg \neg x$	AME#1,23a,27,2	28a-f. t	ner ME.g872.	10/2/07	TT		
le death certificate be exe the attending physician	as the our	Physician/Medical	FEMALE: b. Was decedent pregnan past 12 months?		23c. If yes, outcome of	f pregnancy	Fetal death	3 Ectop	ic pregnancy	23d. Date of Month	f delivery Day Year
ath cer attend	or use		Yes 2 No 9	Unknow	4 Pregnant at time  n g Unknown	e of death _E	Other (Specif	у)			
the dea	ched	2	art II. Other significant co			t not resultin	g in the underlying o	ause given in F			tribute to the cause of death
# 1	e deta	2									Were autopsy findings ava
s tha	onld b	Completed							а	vas an 24b. utopsy erformed?	prior to completion of caus death?
equires that	ze 2 sh	g E								es 2 No	1 🗸 Yes 2 🔃
e law requires tha	r, pag	္တို	5. Was case referred to m	edical			2		h (Check only one)	Desidence 6	✔ Other: Scene
n: The law requires that tificate has been signed	01	ag '	examiner? 1 ✓ Yes 2 N		Hospital: 1 Inpatient	- Land	Outpatient 3 DC	Other 4	Nursing Home 5	ib a baw injury occi	irred
ysician: The law requires that is certificate has been signed	directo		7. Manner of Death		28a. Date of Injury (Month, Day, Year)	)		1 Yes 2	subje	ct was pass cle collisi	enger III verici
ng Physician: The law requires that the certificate has been signed.	uneral directo	2	d Statural		0/20/2007	17	17 pm		etc. 28f. Locat	ion (Street and Nun	ont nber or Rural Route Number Rte. 91 South isterstown, MD
tending Physician: The law requires the teath.  tor: After this certificate has been signer.	the funeral directo	ation: T	1 Natural 5 2 X Accident	Pending Investiga		v - At home			or To	wn. State) 5/15	
or Attending Physician: The law requires the after death. Director: After this certificate has been signer	d in by the funeral directo	tification: T	1 Natural 5 2 X Accident 3 Suicide 6	Investiga Could no	28e. Place of Injury				Alton	dale Rd. Re	isterstown, MD
sspital or Attending Physician: The law requires the hours after death. neral Director: After this certificate has been signer.	y filled in by the funeral directo	Certification: T	2 X Accident 3 Suicide 6 4 Homicide	Investiga Could no determin	28e. Place of Injury of be ned (Specify) St.I	reet			to and due to the	cause(s) and mann	ner as stated.
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To the Hospital or Attending Physician: The law requires the within 24 hours after death.  To the Funeral Director: After this certificate has been signer.	1	2	2 X Accident 3 Suicide 6 4 Homicide 29a. Certifier 1 Certifyone) 2 Medic 29b. Signature and title of	Could no determining Physical Examinater Certifier	28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Place of Injury 28e. Plac	reet  nowledge, d  nation and/or	eath occurred at the investigation, in my	time, date and opinion, death License numb	place, and due to the occurred at the time, per	cause(s) and mann date and place, and 29d, Date si	ner as stated. d due to the cause(s) gned (Month, Day, Year)
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	1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. NO 07 28279								28279				
	Physici	an	1. Decedent's Name (First, Middle							Date of Death     3. Time of Death			
/Medical Cityde Jones									2:30				
	Examin	ier	4a. Facility Name (If not institution Future Care (	4b. City, Town, or Reiste		Death		4c. County of Death					
0	Funeral		5. Social Security Number 223–34–2392		. Age (In yrs. i	last birthday)	If Under 1 Year If Under 2		24 Hrs. 8. Date of Bir		Balt 9.		Imore Birthplace (State or Foreign
	Director		223-34-2392	1 <b>33</b> tM 2□ F	7	75 Yrs.	Months Days	Hours		th, Day, 1		Coun	VA VA
	pu »	Director	Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	eation					1	0d. Inside City Limits
	within 72 hours after death with the Maryland ene. than "natural", or ttems 23a or 28a-f show the Medical Examiner must be notified at		MD Tob. County		10c. City, Town or Location  Baltimore								1x√x Yes 2 □ No
			10e. Street and Number				10f. Zip Code			100	g. Citizen of	What Coun	try?
	3a or st be		1112 Laurens Stre	et						USA	A		
	death	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.	S. 13.	Vas Decedent of Hi f Yes, specify Cuba	spanic Origii	n? (Specify Yes	or No-	14. Rac	ce - Americ	
98	or Ite		1 Never Married 2 Mar	ied 1 ☐ Yes 2 If Yes, Give	<b>XX</b> No		I∐Yes 2⊠ No	Specify:	, acto modify of	o.,			an American
21215-0036	hours tural	ed by	3√2 Widowed 4 □ Divorced  15. Deceden	Year or Dat	es:	16a Deced	lent's Usual Occupa	ation		11	6b. Kind of B		
7.	in 72 n "na n "hadic	Completed	(Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)						of working	III.	OD: 1411G OF D	,	
212	d withil giene. ar than the M	Ę	10	College (1-4	+01 5+)		porter				Johns Ho	pkins	Hospital
nd	be filed within 72 hours after death w ntal Hygiene. Id other than "natural", or Items 23a event, the Medical Examiner must 8	Be	17. Father's Name (First, Middle,	•				18. Mother's	s Name (First, M			ne)	
yla	should be f and Mental I s marked of umatic ever	Tol		de M. Jones		T			Nellie Scott				
Maryland			19a. Informant's Name/Relations Victoria Jones / 1				ling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 W. Lexington Street; Baltimore, Maryland 21223						
	s 1 and 2 f Health item 27 I		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of	;	Date		0c. Location		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1XXBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Loudon Park Cemetery							Ba	altimore	. Marv	land
alti	mit. partm portal y inju		21. Signature of Funeral Service				. Name and Addres	s of Facility	Wylie	Funer	al Home	, P.A.	
8	8 8 <b>3</b> 8 8		Junella	2 your	0		638 N. Gi	lmor Sti	reet; Balt	imore	e, Maryl	and 2	1217
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that can only one cause on ea	used the death ch line.	/		and the same of the same of	ardiac or respira	tory arres	st,	/	Approximate Interval/Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a		Uu	deshups	rull	5			U	Mum
	Medical Examiner physician and the burial-transit		Due to (or as a consequence of):										
		ē	Sequentially list conditions,	b. Due to (c)	r as a nonsequ	consequence of):							
		Examiner	dany, leading to infried at cause. Enter Underlying Cause (Disease or injury that initiated events										
8760,	cate b	dical		d									
9 ×	leath certific attending pl	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy								23d. Date of delivery		
Вох	death certific e attending p id for use as		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live bir	th 2□Feta nt at time of d	death 3	Ectopic pregnancy Other <i>(specify)</i>			_		onth	Day Year
0	at the de by the tached	hysi	9 Unknown	9□Unknov	vn								
or Vital Records, P.	The law requires that ate has been signed page 2 should be de	Completed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?			
										1 Yes 2 Mo 3 Probably 4 Unknown			ably 4 □Unknown
ec			priemin						24a.	Was an autopsy	1	prior to cor	psy findings available npletion of cause of
a F										-	No	death?	2 No
V:E	Physician: this certific ral director,	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hoepital:	nationt 2	EB/Outpotion	. all DOA Othe	ar:		ath (Check only one)			,
Ö	ing After uner	.: To	I impatient 2 Ervoupatient 3 DoA 4 Nursing Home 5 Residence 6 Other (Specify)								Y)		
Division		Certification:	1  Natural 5 Pending (Month, Day Year) Injury Work? 2  Accident 1 Yes 2 No 3 Suicide 4 Homicide determined 1 All Homicide Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homicide 1 All Homi										
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	Fune Fune	edical	29a. Certifier 1 Certifyli (Check only one) 2 Medical	ng Physician: To the b Examiner: On the bas and manne	sis of examina	wledge, deat tion and/or in	n occurred at the tin vestigation, in my o	ne, date and pinion, death	place, and due to occurred at the	time, da	use(s) and m te and place,	anner as s and due to	tated. the cause(s)
	To the Hospital or At within 24 hours after of To the Funeral Direc completely filled in by	Med	29b. Signature and title of carries				29c. License	number		29	d. Date signe	ed (Month,	Day, Year)
	- SF 0		1	(M)			D	L750	-9		914	010	7
2	7		30. Name and ddress of person	who completed chise	of death (Item	23a) (Type,	Print)	1	eene	-		0.	2
7			18110	n Net	T (em	un	1838	4	een	(u	e 1	W	61208
	Sta Registi		31. Date filed (Month, Day, Year)		gistial s Signa	H. E	ande						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 28280 State Registrar Amend 20b, perFH, G871, 9/6/07 entificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Robert Jarrett 08-30-2007 12:38pM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5825 Timberview Dr. Elkridge Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 512-28-5579 74 08-03-1933 Director NC Usual Residence of Decedent 10c. City. Town or Location 10a State 10d. Inside City Limits 10h County ral", or Items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 No Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5825 Timberview Dr. 21075 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 207 No If Yes, Give 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygient Important: If item 27 is marked other this any injury or other traumatic event, the, once. the Steel Worker Steel 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carson Jarrett Cola Mae Daves ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Jarrett / Wife 5825 Timberview Dr., Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 09 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park 1<del>08</del>/03/2007 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, 7250 Washington Blvd., Elkridge, MD ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. ry. Enter the diseas Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTADIC **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☐ No 1 | Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ScertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

House it foods

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COVIEW

SEP 0 5 2007

31. Date filed (Month, Day, Year)

6569 N. CUALLE

32. Remarar's Signature

027730

State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month KILLE TTE Year **Physician** 10.20PM RICHARD 2007 29 AUG /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTINONE HUZPICAL UNIVERSITY SPECIALIT BALTINONE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days **Funeral** Months Hours **™** M 2□ F 63 217-42-5649 MD 08 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location hours after death with the Maryland 10b. County r 28a-f show notified at 10a. State 1 X Yes 2 ☐ No Baltimore NA Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or Items 23a or the Medical Examiner must be i 21206 U.S.A. 4907 Goodnow Road Apt G Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 Elementary/Secondary (0-12) College (1-4or 5+) Truck Drive Bakery 12th grade na marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Evelyn Johnson Lawrence Killette Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Md 21206 Kenneth Killette-Son 4907 Goodnow Road Apt G, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 9/6/07 Baltimore, Md 21. Signature of Funeral Service Licenses March F/n West Solon 21215 4300 Wabash Ave, Baltimore, Md 11 lax Approximate Interval Between Onset and Death 23 Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ENCEPHALOPATHY Immediate Cause (Final **Physician** disease or conditior resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine DECUBLINS ULCERLS MU JIPLE be executed burial-transit Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical The law requires that the death certificate 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an cate has t autopsy 22 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this 28b. Time of 28d. Describe how injury occurred funeral 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death After (Month, Day Year) Injury 1 ☑ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signafure and title of certifier ATTENDING 00056948 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) no 21217 SUITE 34 BALTINONE PLAZE 300 ARMONT 00 TANO Amnma 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2007

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12:15AM Jozka Z. Kucera September 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Harwood Mandrin House If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F 578-50-6229 85 Director AUG 10 1922 Czechoslovakia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d, Inside City Limits 10b. County 1 ☐ Yes 2X No Director MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12216 Maycheck Lane 20715 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Editor Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Kucera Zdenka Poes1 ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blanka Kucera - wife 12216 Maycheck Lane, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 9/4/2007 4 Donation 5 Dother (Specify) Baltimore, MD 21. Signature of Funeral Service Scenery H. Williams ²² Name and Address of Facility Cremation Society of Maryland, 299 Frederick Road, Baltimore, 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician resulting in death) /Medical Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate the leading to immediate the leading to immediate the leading to immediate the leading to the leading that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown cate has been si, , page 2 should b Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate I 2 1No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Pother (Specify) Hospice 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) Registrar's Sig State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 24 2007 7:30 AM August Ellen Kearney /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 7200 Talisman Lane Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
NOV. 1,1947 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🕱 F Months Days Hours New York 59 Director 564-74-7513 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Director Examiner must be notified Howard Columbia Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21045 U.S.A. 7200 Talisman Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ⊆ ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Transcriptionist Columbia Medical Plan Department of Health and Mental High Important: If item 27 is marked other any injury or other traumatic event, I once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winifred Carroll Dominic McNally ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Kearney (Husband) 7200 Talisman Lane Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Memorial Pk. 8-29-2007 Clarksville, MD 21. Signature of Funeral Service Licenses Witzke Funeral Homes, Inc. 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. 5555 Twin Knolls Road Columbia, MD 21045 Fi BriCakon Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ò 102 ten 87091 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of a. Was an autopsy performe 2 No death? 2 □ No Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only pne) Hospital: 1 Yes 2 No Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 ☑ Natural 28c. Injury at Work? 28d. Describe how injury occurred Certification: rilled in by the funera 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature a 5AVW 30. Name and cause of death (Item 23a) Type, Print) 1 a X Rut 164 uno 31. Date filed (Month, Day, gistrar's Signature

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene, 28284 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Eric Jerome Lee, Sr. 0423 AM AUGUST 30 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SAINT AUNES HOSPITA Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 XM 2 ☐ F 58 Jul 12, 1949 Maryland 219-52-4872 Director Usual Residence of Decedent permit. Pages 1 and 2 should be illed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or items 220. 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 Yes 2 □ No Baltimore N/A Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 USA 217 South Hilton Street Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1970 1 ☐ Yes 2 ☐XNo Specify. Black þ 3 Widowed 4 Divorced 1973 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University Md. Baltimore Elementary/Secondary (0-12) College (1-4or 5+) Chef 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Williams Quincy A. Lee ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 155 East Godfrey Avenue-504 Philadelphia, Penn. 19120 Erika Lee Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Owings Mills, Md. 09/06/07 Garrison Forest Veterans Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee Estep Brothers Funeral Service, P.A. 1300 Eutaw Place Baltimore, Md. 21217 14 Approximate Interval Between Onset and Death 23a. Part1. Errer the disease, or complications that caused the death. shock, wheart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** disease or condition resulting in death) /Medical sequence of) Examiner Sequentially list conditions, if any leading temperature cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-tran and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) Yes 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? 2 🗀 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 1 🔛 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death al or Attending P Medical Certification: Injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D41843 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) BALTIMORE, MO &1229 REE CATON 00 32. Registrar's Signature 31. Date filed (Month, Day, Year) State CONT. S Registrar SEP 0 5 2007

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

121

State of Maryland / Department of Health and Mental Hygien 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Lillian Irene Lipper 2 2007 3:00 PM Sept /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles Waldorf Waldorf Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours 1 □ M 2 🗓 F 460 58 2074 87 1920 Kansas **Director** Jan 11. Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 28a-f show or then "natural", or Itama 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ XNo Maryland Prince George Clinton Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20735 United States 7511 Berkshire Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 Tro Specify: Specify: White à 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 ith and Mental Hygid 27 is marked other r treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 12 should be f h and Mental h Lillian Ruby Sylvester Alcorn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7511 Bershire Drive, Clinton, MD 20735 Pages 1 and 2 ment of Health a ant: If item 27 Is Lola I. Withers(Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXxremation 3 ☐ Removal from State Department of Important: If eny injury or once. Lee Crematory Sept 4,2007 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityLee Funeral Home, Inc 21. Signature of Funeral Service Licent m01284 Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying; such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine to the Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 2 Yes 2 No 2 Fetal death 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 1 Yes 2□ No certificete Division of Vital 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA his After thi funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide within 24 hours eff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 M.D. 12070 Old Line#207, Waldorf, MD 20601 lip-Wisotsky 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 200 1 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and numb Examiner TON EXTE PEDEARE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year April 23, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Year) Days Min. 1**∑** M 2□ F Director 216 01 2427 April Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show 1X Yes 2 ☐ No Maryland N/A Baltimore Director 10e. Street and Number 10g. Citizen of What Country? 3310 Benson Avenue Apt. 118 U.S.A. 21227 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examiner must anone. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Deyes 2 □ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🕱 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fire Clean Up State of Maryland 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgie Linton / Wife 3310 Benson Avenue Apt. 118 Baltimore, MD. 21227 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MD State Veteran Cem. 9/6/2007 4 Donation 5 Other (Specify) Crownsville, Maryland 22. Name and Address of Facility 21. Signature of Juneral Service Licensee Gonce Funeral Service, P.A. Ritchie Highway Baltimore, Maryland 21225 4001 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 2 🗆 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No s after death.

I Director: After this of in by the funeral dire 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined within 24 hours a To the Funeral I 29a. Certifier ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day,

OCH RAVEN BLYD

cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

			For	State of Ma	aryland / De	Indelible Ink.		ental Hygia	ene	00007	
		•	= State Registrar Amend #8, per	FH, G871, 9/	5/07 TT (	Certificate of	Death	Reg	. No 2007	28287	
1. Decedent's Name (First, Middle, Last)  Physician  (Medical								Day Year 28 2007	3. Time of Death $U: \mathcal{OSP}^{M}$		
	Examin	- 4	4a. Facility Name (If not institution, give			2 1	Location of Death		4c. County of Death		
	Funeral		5. Social Security Number 418-46-3177		HTMOR	day) If Under 1 Year	ORE CITY	8. Date of Birth 2	<b>/21/1936</b> 9. Birth ear) Cou	place (State or Foreign	
	Director		418-46-3177  Usual Residence of Decedent	1 <b>⊠</b> M 2□F	71 Y	s. Months Days	Hours Min.	02/02/		ABAMA	
	aryland show d at	_	10a. State 10b. County	N/A	10c. City, Town	BALTIMORE	стту			10d. Inside City Limits  YYYes 2 □ No	
	the M 28a-f notifie	Director	10e. Street and Number			10f, Zip Code	. 0111	100	. Citizen of What Cou		
	th with	al Di	4001 SPRINGE	DALE AVEN	UE		207		USA		
936	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2□ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Be Armed Forces? 1  Yes 2 Y		<ol> <li>Was Decedent of H If Yes, specify Cuba</li> <li>1 ☐ Yes 2 X No</li> </ol>		cify Yes or No- lican, etc.)	14. Race - Ameri Black, White, Specify: B		
2-0	72 hor	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. C	ecedent's Usual Occup Give kind of work done i ife. DO NOT use retired	ation during most of working	9 16	GROSS ME	dustry CHANTCAL	
21215-0036	be filed within 72 ho ital Hygiene. dother than "natur event, the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+1	ife. DO NOT use retired CHINE OPE			LAB		
Maryland	executed my bermit. Pages 1 and 2 should be be secuted by My My My My My My My My My My My My My	To Be C	17. Father's Name (First, Middle, Last) CLARENCE LITTLE, SR.						lle, Maiden Surname) JL MOORER		
			19a. Informant's Name/Relationship DAMON LITTLE			Mailing Address (Street 4001 SPR)	INGDALE A	AVENUE,	BALTIMO	RE 21207	
O. Box 68760, Baltimore,			20a. Method of Disposition  **X***Burial 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Speci		cemetery	Disposition (Name of crematory or other place MEM. PARE	ce) ¦ .		Oc. Location - City or T WINDSOR		
			21. Signature of Funeral Service Lice		2.70	22. Name and Addre	. 110		UNERAL HOVE BALT	OME 21207 IMORE, MD	
		l Examiner	23a. Idia Tiler the Sease, or con sychoche a ailure. List only Imme in a Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. GEDue to (or as b. VENT)  Due to (or as c.		HERYTHI		respiratory arres	it,	Approximate Interval Between Onset and Death 2 days	
		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	y		23d. Date of delive	ery Day Year	
ds, P	signed by	d by Pr	Part II. Other significant conditions	contributing to death b	ut not resulting in t	he underlying cause giv	ren in Part I.	23e. Did toba	acco use contribute to	the cause of death?	
Division or Vital Records, P.O.	The law requate has been age 2 shoul	Completed by						24a. Was an autopsy performe	ad2   daath2	opsy findings available ompletion of cause of	
Vita	ician: Sertifica Sector, I	Be	25. Was case referred to medical examiner?	Hoonital:		Louis	26. Place of Death				
on or	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bur	ion: To	1 Yes 27 No  27. Manaer of Death  1 Natural 5 Pending investigatic	Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Sp. 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?    28b. Time of Injury Work?   28c. Injury at Work?   1 Yes 2 No						fy)	
Divisi		Certification:	2 Accident Investigation 3 Suicide 6 Could not to 4 Homicide determined	De Blace of inju	ury - At home, farr c. (Specify)	n, street, factory, office		8f. Location (Stree City or Town,	(Street and Number or Rural Route Number, wn, State)		
		Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
		Me	29b. Signature and title of certifier			29c. Licens		290	d. Date signed (Month	Day, Year)	
landwadhavan, MD							-000	August 28	,2007		
	4		30. Name and address of person who	HUMANI MA	SINA	1 HOSPITAL	OF BA	-LTIMOR			
I	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 5 200	32. Registra	ar's Signature	este					
	riegisti	· · ·	9EL 0 9 700	- January							

DHMH 17 Rev 1/2001

		,	. 101	artment of Health and Mental Hygiene rtificate of Death Reg. Na 2007 28288							
	Physici Medic		1. Decedent's Name (First, Middle, Last) YKao Lee	2. Date of Death Month Day Year September 2 2007 5/2 PM							
7	Examin		4a. Facility Name (If not institution, give street and number)  Nov-Howest Hospital	4b. City, Town, or Location of Death  Paral III Town  If Under 1 Year I If Under 24 Hrs. 8. Date of Birth  9 Birthplace (State or Foreign							
14	Funeral Director	ector	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 DM 2 F Yrs.  Usual Residence of Decedent	If Under 1 Year   If Under 24 Hrs.   8. Date of Birth   Months   Days   Hours   Min.   Month, Day, Year   Gounts   Gounts   Min.   Month, Day, Year   Gounts   Goun							
	he Marylan 8a-f show otiffed at		10a. State         10b. County         10c. City, Town or L           MD         BALTIMORE         BALTIMORE	a€, 1 □Yes 2 No							
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number           9036 LIBERTY ROAD           11. Marital Status         12. Was Decedent Ever in U.S.         13.	10f. Zip Code  21133  Was Decedent of Hispanic Origin? (Specify Yes or No-  14. Race - American Indian,							
9036		by	1 ☐ Never Married 2 ☑ Married I ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☐ No Specify:  Specify:  TAIWANEES							
21215-0036		To Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired)  16b. Kind of Business/Industry							
			17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)							
Ĕ			19a. I ant's Name/Relationship (Type. Print) 19b. Mail	Representation of Rural Route Number City or Own, State, Zip Code) 21/33							
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Bail	permit. Pag Department Important: I any Injury o		21. Signatur of Funeral Service Licensee  22. Name and Address of Facility House I Forme 21201  When Mush How his harty Heights Acte, Buste. His								
,d. F	The law requires that the death certificate be executed as the base of the attending physician and an are reached for use as the burial-transit and be detached for use as the burial-transit.		23a Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	Onset and Death							
		/Medical Examiner	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate the first funderlying.  Due to (or as a consequence of):								
8760,			Cause (Disease or injury that initiated events resulting in death) Last  C								
Box 687			IF FEMALE: 23c. If yes, outcome pf pregnancy	23d. Date of delivery							
P.O. Bo		Physician/Med	in the past 12 months?	□Ectopic pregnancy							
ords, r		Completed by P	Part II. Other significant conditions contributing to death but not resulting in the t	anderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4 ☑ Unknown							
H Kec				24a. Was an autopsy performed? 1 ☐ Yes ②□No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes ②□No 1 ☐ Yes 2 ☐ No							
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	sician certifi rector	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death (Check only one)							
0	Phys rat di	<u>ا</u>	1  Yes 2  No	111 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)							
Division or Vital Records,	To the Hospital or Attending Physician: The within 24 Hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, p. ge	cal Certification:	15 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 3 Suicide 6 Could not be determined to the determined of the state of injury. At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,								
<u>.</u>			29a. Certifier  (Check only  29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	ro the H within 24 To the Fl complete	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)							
7	8		30. Name and address of person who completed cause of death (Item 23a) (Type Jessa Edelman ND	D006611 September 2,2007							
	Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar's Signature	uls							

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28289 Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Lest) 4:43PM ambert 2007 09 amryn 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number niversity of Maryland Medical Center NIA Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day 0Ct. 10 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Yea() 5. Social Security Number Days 1 ☐ M 2 🛛 F MD 217-53-6436 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Pasadena Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21122 USA 7661 Cedar Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Elementary Education Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emory Jaime Christopher N. Lambert Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7661 Cedar Drive, Pasadena, MD 21122 Debra Katzenberger (step-mother Sept. Date 06 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Qonation 5 □ Other (Specify) Glen Burnie, Maryland Glen Haven Cemetery 2007 Stallings Funeral Home, P.A. 22. Name and Address of Facility 21. Signature of Funeral Se 3111 Mountain Road, Pasadena, MD 21122 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on caun line. Approximate
Interval Between
Onset and Death
25 minuts Pneumo thorax Immediate Cause (Final Temsion

**Physician** /Medical Examiner

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

been signed by the a should be detached within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director.

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

ical Examine	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Presumed Pulmonary Aspergil  Due to (or as a consequence of):  Pancyto penia  Due to (or as a consequence of):  Leykemia	losis	~16 days ~5 weeks 4 years
ysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of Month	delivery Day Year
ompleted by Pn	Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.	24a. Was an autopsy performed?	Probably 4 Unknown  e autopsy findings available to completion of cause of
3	25. Was case referred to medical	26. Place of Death	(Check only one)	
0 26	overninor?	Othor:	me 5 Residence 6 Other (	Specify)
TION: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of lnjury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number of City or Town, State)	r Rural Route Number,
dical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	vsician: To the best of my knowledge, death occurred at the time, date and place, iner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cause(s) and mannered at the time, date and place, and	er as stated. due to the cause(s)

State Registrar

0

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

0

leuton UD D005069 S

1 cause of death (Item 23a) (Type, Print)

VENSON 22 South Greene Shreet #N5E13 32 Registrar's Signature

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			For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H <i>rtificate of L</i>			iene <b>z († ()</b> 19. No.	28290
w.'	· **		1. Decedent's Name (First, Middle, Las	it)				2. Date of Deat Month	h Day Year	3. Time of Death
H	Physicia /Medic		Kathryn Margare	et Moore					er 2, 2007	6:45P M
	Examin	:3	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	th
- 60°C		May.	Chapel Hill Nurs				11stown If Under 24 Hrs.	0 D	Balti	
3 2	Funeral		5. Social Security Number 6. S	□ 14 a771 E	e (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, May 31,	Year) 9. Bir	thplace (State or Foreign ountry)  MD
JR.	Director		219-32-6013 Usual Residence of Decedent		/1			may 31,	1930	FID
	ehow		10a. State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Limits
	Marfet	ţċ	MD Baltimo	ore	Randa1	1stown				1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	23a	Tal L	3808 Brentford			211			USA	
	ar deg	Funeral	11, Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Bfack, Whi	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:	No	1 ☐ Yes 2X No	Specify:		Specify: Wh	nite
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212	d within giene. er then "	E O	11	Conlege (1 401 c		ax Prepar	er		H & R B1	ock
b	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	Maiden Sumame)	
yla	2 should be filed within and Mental Hygiene. Ia marked other then aumatic event, the Mis	2	Guthrie L. Strauss					or Zentz		
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Maryla nt of Health and Mental Hygiene. If item 27 is marked other then "nature!", or items 23s or 28s-f show or other traumatic event, it is Medical ESD place market be recified at		19a. Informant's Name/Relationship (						, City or Town, State,	
	1 and Health em 27 other tr		Barbara A. Daile  20a. Method of Disposition	7 Daugh	ter 3496 20b. Place of Disp				stown, MD 20c. Location - City o	21136
Baltimore,	Pages Inent of Hunt: If ite		1 X Burial 2 ☐ Cremation 3 ☐		cemetery, cre	matory or other plac	(e)		•	
Ę			4 □ Donation 5 □ Other (Specifical Service Licer			Forest Ve 2. Name and Addres			Owings Mi	
Ba	Departr Departr Imports eny inj		3	Pline		line Fune			Reistersto rstown, MD	
			3a. art1. Enter the disease, or com	plications that caused	the death. Do not en					Approximate
	West Str	$\triangleleft$	shock, or heart failure. List only Im ediate Cause (Final	one cause on each li	ne.	0				Interval Between Onset and Death
	Physician /Medical		discase or condition resulting in death)	u	a consequence of):	ills				
	Examiner			seve	e be	ubher	alu	evo cu	lan d	iceasa
	7 -	ner	Sequentially list conditions,	Due to for as	a consequence of					
$\checkmark$	licate be executed physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
68760,	oe exection a	ŭ	resulting in death) Last	Due to (or as	a consequence of):					
87	physic the t	dica		d						
	⊕ Op or		IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of de	alivary
Вох	that the death certifi ed by the attending detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _			Month	Day Year
O.	0 0	Jysh	1 ☐ Yes 2. ☒ No 9 ☐ Unknown	9 Unknown						
٩.	iaw requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	quire on sig uld b							192(Y)	es 2□No 3□F	Probably 4 Unknown
ပ္တ	aw re s bee	Completed						24a. Was a autops	an 24b. Were a	autopsy findings available completion of cause of
Ä	e ← e	E						perfor	med?   death?	s 2 No
ita	tician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only or	18)	
of Vital Records,	hysic his ce Il dire	2	1 ☐ Yes 2 No		ent 2 ER/Outpatie		Wursing H		ence 6 Other (Sp	ecify)
	ing P		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time Injury	Wor		28d. Describe h	ow injury occurred	
Sio	tend Jeath tor: /	cat	2 Accident investigatio 3 Suicide 6 Could not b	θ Oge Diego of Ini	ury - At home, farm, s		Yes 2 □No	28f Location (S	treet and Number or F	Pural Poule Number
Division	or A after Direction by	Certification:	4 Homicide determined		c. (Specify)	treet, factory, office		City or Tow		Tarar Floure Nembor,
-	spital ours neral filled	Ö	29a. Certifier Certifying Pt	ysician: To the best	of my knowledge, dea	th occurred at the tir	ne, date and place	, and due to the c	ause(s) and manner a	as stated.
	ne Ho 24 t ne Fui	Medical	(Check only 2 Medical Examone)	niner: On the basis o and manner st	f examination and/or i ated.	nvestigation, in my o	pinion, death occu	rred at the time, o	late and place, and du	ue to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	M	29b. Signature and title of certifier			29c. Licens		-2	29d. Date signed (Mor	nth. Day, Year)
	/		Hawer	fr.		12	5112		04104	2001
	15		30. Name and address of person who	completed cause of c	death (ftem 23a) (Type	Print)	MILO C	oiloimi	Owinc	is Hills
			10010	do Poniet	rada Cicantura		110000	110/10/	MD	21117
	Sta Regist		31. Date filed (Month, Day, Year)  SEP 0 5 200	7 Per hegisti	rar's Signature	alle I				
-	and the second		SEP 0 3 200	1 polarise	10 mayor	-				

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	Sta Registr	
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Alien Lee Nyvers, Jr.   As really have for demillation, see what and number   As really have for demillation, seeked and number   B. Court of Deciment   Court of Deciment   B. Court of Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment   Deciment	ian	1. Decedent's Name (First, Middle	e, Last)							Death	1.70	3. Time of Death
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19a. Informant's Name-Relationship (Type   Print)   19b. Mailing Address (Street and Number or Paral Route Number. City or Town, State, Zip Code)	Be		•								,	
Sarah E. Myers (Wife)   1030 Nicodenius Road; Reisterstown, Maryland 21]	우				19h Ma	ilina Address	(Street				-	Zin Codo)
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Veterans Cemetery 2007   Ovings Mills, Mary 2   21. Signings of followiskings of Facility   Schhardt Fruncial Chapel, P.a.	10	20a. Method of Disposition	, , , , , , , , , , , , , , , , , , , ,	20b. F	Place of Dis	position (Nam	e of	>	Date			
23. Fight Enter the disease, or complications that caused the death. Do not emert he mode of dying, such as cardiac or respiratory arrest.  23. Part Enter the disease, or complications that caused the death. Do not emert he mode of dying, such as cardiac or respiratory arrest.  23. Part Enter the disease, or complications that caused the death. Do not emert he mode of dying, such as cardiac or respiratory arrest.  23. Part Enter the disease, or complications that caused the death. Do not emert he mode of dying, such as cardiac or respiratory arrest.  25. Part I arry, leading in death)  26. Place of delivery into in medical death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of th				°   Ga∶ Ve	teran:	s Cemei	ers	7 : 200	o. 7, 07	Ow	inas Mi	lls. Marylan
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Due to (or as a consequence of):    Sequentially list conditions largy leading to immediate Cause (Closes Continue)	ļ		only one cause on each	line.	n. Do not e	enter the mode	of dyir	ng, such as cardia	ac or respirato	y arrest,		Approximate Interval Between Onset and Death
Sequentially list conditions.  If any legiding to immediate cause. Enter Underlying to immediate cause. Enter Underlying to immediate cause. Enter Underlying resulting in death) Last    Due to (or as a consequence of):		disease or condition	a			1 4 6 44		MALA	^7			Yrs
Due to (or es a consequence of):    Due to (or es a consequence of):				a conseq	derice oi).							
IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   yes   2   No   3   Unknown   23d. Date of delivery   Month   Day   Yea   2   No   3   Unknown   2   2   No   3   Probably   4   2   2   No   3   Probab		if any, leading to immediate cause. Enter Underlying		s a conseq	uence of):							
FFMALE:   236.   If yes, outcome pf pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   3   Dither (specify)   23d. Date of delivery   Month   Day   Yea   Yea   2   Yea		Cause (Diseese or injury that initiated events	c		uanaa afti							
23. Did tobacco discontributing to death but not resulting in the underlying cause given in Part.   23. Did tobacco discontributing to the cause of death   1   Yes   2   No   3   Probably   4   Monk   24a. Was an autopsy performed?   1   Yes   2   No   1   Y	_	<b>,</b>	Due to (or a	s a consequ	uerice or).							
25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  28. Date of Injury  (Month, Day Year)  28. Date of Injury  28. Date of Injury At home, farm, street, factory, office  28. Location (Street and Number or Rural Route Number (Check only one)  28. Date of Injury At home, farm, street, factory, office  29. Certifier (Check only one)  29. Signature and title of certifier  29. Signature and title of certifier  29. Signature and title of certifier  29. License number  29. License number  29. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  28. Date flied (Month, Day, Year)  29. License number  29. Date signed (Month, Day, Year)  31. Date flied (Month, Day, Year)  32. Date flied (Month, Day, Year)  33. Date flied (Month, Day, Year)  34. Date flied (Month, Day, Year)  35. Date flied (Month, Day, Year)  26. Place of Death (Check only one)  26. Place of Death (Check only one)  26. Place of Death (Check only one)  27. Manner of Death (Check only one)  28. Date of Injury at Work?  28. Date of Injury at Work?  28. Date of Injury at Work?  28. Date of Injury occurred  28. Location (Street and Number or Rural Route Number City or Town, State)  29. Location (Street and Number or Rural Route Number City or Town, State)  29. Location (Street and Number or Rural Route Number City or Town, State)  29. Location (Street and Number or Rural Route Number City or Town, State)  29. Location (Street and Number or Rural Route Number City or Town, State)  29. Location (Street and Number or Rural Route Number City or Town, State)  29. Location (Street and Number or Rural Route Number City or Town, State)  29. Location (Street and Number or Rural Route Number City or Town, State)  29. Location (Street and Number or Rural Route Number City or Town, State)  29. Location (Street and Number or Rural Route Number City or Town, State)	earc -		d									
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25. Was case referred to medical examiner?  1	מפ											
25. Was case referred to medical examiner?    1	g .								a	utopsy erformed	prior to	completion of cause of
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29a. Certifier (Check only one)  1		_/	(Administration C)			of 28	Bc. Injur Wor	y at k?	28d. Descri	be how ir	njury occurred	
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  29a. Certifier (Check only only only only only only only only		2 ☐ Accident investig	ation of he					Yes 2 □No				
29a. Certifier (Check only one)  1			ined 28e. Place of Ir building, e	etc. (Specify	ome, tarm, s	street, factory,	office					Rural Route Number,
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature		29a. Certifier 1 Certifyin	g Physician: To the bes	t of my kno	wledge, de	ath occurred a	t the tir	me, date and plac	e, and due to	the cause	e(s) and manner	as stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  1/4 Replace (Month, Day, Year)  32 Registrar's Signature	ealc	(Uneck only 2   Medical	<b>Examiner</b> : On the basis	of examina	tion and/or	investigation,	in my o	pinion, death occ	curred et the ti	ne, date	and place, and d	ue to the cause(s)
31. Date filed (Month, Day, Year) 32. Degistrar's Signature	Ξ											
31. Date filed (Month, Day, Year) 32. Legistrar's Signature	_						03	15885			7/4/5	> 7
a 31. Date filed (Month, Day, Year) 32. Legistrar's Signature			1	death (Item		e, Print)	200.	fan fo	)~~,	nn	7/	17:
SEP 0 5 2007 Mayers IX Angells 8	te	31. Date filed (Month, Day, Year)	32 egis	rar's Signa	ture	.4	~ ~			1012	~ / /	1 3 7
2001			2007	Part L	x A	ments						

		1	For State Registrar	State of Ma	ryland / I	Cert	rtment of H	eaith and iv Death	-		007		
	Physicia		1. Decedent's Name (First, Middle, Last						2. Date of Deat Month	h Day	Year	3. Time	
	/Medic	al -	Charles Howell		[]		41. O't. T	Leasting of Dooth	Septembe	_	2007 unty of Death		:00P ^M
1	Examin	er	4a. Facility Name (If not institution, give				Aberde	Location of Death		40.00	Harfo		
			1539 Perryman  5. Social Security Number 6. Se		(In yrs. last bi	irthday) _	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Ma aul	9. Birth	place (State	or Foreign
	Funeral Director		212-52-9161	<b>S</b> M 2□F	54	Yrs.	Months Days	Hours Min.	DEC 30	1952	Ala	bama	
	yland now at		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	vn or Loc	ation					10d. Inside	
	Mar a-f sk	ctor	MD Harford	d l	Aber	deen							s 2 No
	th the	Director	10e. Street and Number				10f. Zip Code		1		of What Cou	untry?	
	ath w		1539 Perryman Roa			40.14	21001	·	- sit - Van av Na		USA Race - Amer	ican Indian	
736	be filed within 72 hours after death with the Maryland that Hyglene.  di other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1   ↑ Naver Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)		Black, White		
21215-0036	72 hou 'natura dical E	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	168	a. Deced	ent's Usual Occup	ation during most of work f)	king	16b. Kind	of Business/I	ndustry	
121	filed within Hygiene. Ither than "	dwo	Elementary/Secondary (0-12)	College (1-4or 5-	) M	echa		"		Auto	motive		
D	should be filed nd Mental Hygi marked other ımatic event, ti	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Nam	,		ırname)		
<u> a</u>	should be f and Mental I s marked of umatic eve	10 B	Charles H. Moltr	up, I					th Wagne				
Maryland	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (7				•	and Number or Ru					
	1 and 3 Health em 27 other tr	- }	Elaine Fender - s	ister				e, Unit 1			MD ZI		
altimore,	permit. Pages 1 al Department of Hes Important; If Item any Injury or othe		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify			o Cr		Inc. 9/4	1/2007	Balt	imore,	MD	
Balt	permit. Depart Import any Inj once,		21. Signature of Funeral Service Ligen	even H. Wi	11iams	22	Name and Addre	ss of Facility n Society erick Roa	of Mary	land	, Inc.	21228	
58760,6	Physician and Medical Examiner transit sthe burial-transit	edical Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the sta	b. Due to (or as a Due to (or as a d	a consequence	e of):		e, bva		est,		Approxin Interval E Onset ar	Between
Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 🗆 Fetal dea		Ectopic pregnanc Other (specify)	у		23	d. Date of del Month	ive <b>ry</b> Day	Year
rds, P.	quires that n signed by	by	Part II. Other significant conditions o	ontributing to death bu	ut not resulting	in the ur	nderlying cause giv	ven in Part I.	23e. Did to		ocontribute to	the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the c	
or Vital Records, P.O.	Physician: The law requir this certificate has been si al director, page 2 should	Completed							24a. Was a autop perfor	sy med?_	24b. Were au prior to death? 1 □ Yes	utopsy findin completion o	gs available of cause of
ita	slan: ertifica ctor,	Be (	25. Was case referred to medical examiner?				100		th Check onl of	ne			
7	Physiclan: r this certific ral director,	은	1 Yes 2 No		nt 2 ER/0	Outpatier		4 🗆 Nursing H	lome 5 Resid			cify)	
Division (	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.	Certification:	27. Manner of Death  1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		y Year)	Injury	Wo	rk?  Yes 2∐No	28f. Location (S			ural Route N	lumber,
<u>≥</u>	al or A s after al Direction	Certif	4 ☐ Homicide determined	building, et	c." (Specify)				City or Tow	n, State)			
	Hospit 24 hours Funera etely fille	Medical (	29a. Certifier 1  Certifying Ph (Check only one) 2  Medical Exam	ysician: To the best niner: On the basis o and manner sta	f examination	dge, deat and/or in	h occurred at the to vestigation, in my	ime, date and place opinion, death occi	e, and due to the urred at the time,	cause(s) a date and p	and manner as place, and due	s stated. e to the cau:	se(s)
•	To th within To th comp	Me	29b. Signature and title of certifier	mesma	no 1	MD	29c. Licens	oe number 20253	34	29d. Date	3/07	th, Day, Yea	r)
	3		oci italio and addition	MAND MI	eath (Item 23a	01 10	J. CHAR	LES ST.	Soute ?	1326	Tow	son A	10 2120
		ate	31. Date filed (Month, Day, Year)	39. Registr	ar's Signature	don	di						
	Regist	rair	SEP 0 5 200	11 11000	of the s	Par par							

		State of Maryland / D	repartment of Health and Mental Hy Certificate of Death	/giene2007 2829
Physic		1. Decedent's Name (First, Middle, Last)  MARY MCMAR	2. Date of D Month AuGus	Day Year
//Medi Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		NORTHWEST HOSPITAL	RANDAUSTONN	BALT, MOILE
Funeral Director		210 42 0100	nday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Bi	9. Birthplace (State or Fore
Maryland a-f show ified at	tor	Usual Residence of Decedent  10a. State	or Location  Baltimore	10d. Inside City Lim 1 ☐Yes 2 ☐
h with the	al Director	10e. Street and Number 9909 Shone Way	10f. Zip Code <b>21133</b>	10g. Citizen of What Country? U.S.A.
Lar y failed & I.E. 13-13-13-13-13-13-13-13-13-13-13-13-13-1	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Wivorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)     □ Yes 2□ No Specify:	o- 14. Race - American Indian, Black, White, etc. Specify: Black
within 72 hc ene. than "natu he Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) 12	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pharmacy Technician	16b. Kind of Business/Industry  Neighbor Care
lid be filed lental Hygi ked other itc event, th	To Be Co	17. Father's Name (First, Middle, Last) George C. Hardman	18. Mother's Name (First, Middle Eth	e, Maiden Surname) a S. Hardman
nd 2 should be and N 27 is mar	-	19a. Informant's Name/Relationship (Type. Print)  Rosetta Foote	Mailing Address (Street and Number or Rural Route Num. 1111 Lyndhurst Street Baltimore, Mar	ber, City or Town, State, Zip Code) yland 21229
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Rurial 2 Xramation 3 Removal from State	Disposition (Name of Acrematory or other place)  Metro Crematory, Inc.  22. Name and Address of Facility Estep Brothers Funeral Service 1300 Eutaw Place Baltimore, I	
w requires that the death certificate be executed  Medical  Beau Medical  Beau signed by the attending physician and should be detached for use as the burial-transit	lical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence or cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence or death)	(): ():	arrest, Approximate Interval Between Onset and Death
that the death certificate ed by the attending phys detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery  Month Day Year
requires that een signed by hould be deta	þ	Part II. Other significant conditions contributing to death but not resulting in	, ,	tobacco use contribute to the cause of death
The law recicate has been recreased to page 2 shours.	Completed		per	s an 24b. Were autopsy findings avail prior to completion of cause death?  2 No 1 Yes 2 No
rsicial s certi lirecto	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	26. Place of Death (Check only patient 3 □ DOA Other: 4 □ Nursing Home 5 □ Res	
To the Hospital or Attending Physician: The law requires the within 24 hours after death.  To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be	Certification: To	27. Manner of Death 1 ⊠Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	me of Jasc. Injury at Work?  M 1 Yes 2 No	how injury occurred
pltal or Al urs after c eral Direc	Certifi	4 Homicide determined 25e. Place of injury - At nome, fair building, etc. (Specify)	City or To	(Street and Number or Rural Route Number, wn, State)
the Hosp thin 24 hou the Fune	Medical	29a. Certifier  (Check only one)  1. Certifying Physician: To the best of my knowledge, 2	death occurred at the time, date and place, and due to the for investigation, in my opinion, death occurred at the time 29c. License number	e, date and place, and due to the cause(s)
S 2 1 2 2	=	29b. Signature and title of certifier		29d. Date signed (Month, Day, Year)
,		30. Name and address of person who completed cause of death (Item 23a) (1	D00 5 9 73 6  Type, Print)	August 29, 2007
Sta	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature	ROPETANEST HOSPITAL SY	OI OLD COURT ROAD

0 5 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 1 1 7 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** eplember Manning Dennis /Medical Facility Name (If not institution, give street and number) 4h. City. Town-or Location of Death Examiner Date of Birth (Month, Day, Year) July 31,1944 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days New York 64 Director 069-36-6039 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director Indian Head Maryland | Charles 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number o e U.S.A. 20640 Items 23a 5751 Cabinwood Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No 1965-If Yes, Give Year or Dates: 1967 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married "natural", or 1 ☐ Yes 2 ☐ No Specify. White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and 2 should be filed within ealth and Mental Hygiene. the Me Elementary/Secondary (0-12) College (1-4or 5+) Capital Police Police Officer 12th Is marked other land 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jane Cummingham Manning ပ Rodney Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5751 Cabinwood Ct. Indian Head, Maryland 20640 19a. Informant's Name/Relationship (Type. Print) Judith K. Manning (Wife) Important: If item 27 | any Injury or other tra Date 8, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Sept. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Clinton, Maryland 4 Donation 5 Dother (Specify) Lee Crematory 2007 21. Signature of Foneral Service Vicenses 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 23 and art1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, myocardial Infarction Immediate Cause (Final **Physician** Haurs. disease or condition resulting in death) /Medical Due to (or as a consequence of): arterial disease Examiner Years COLONALY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed Due to (or as a consequence of) attending physician al for use as the burial-I .O. Box 68760, Physician/Medical as IF FEMALE: 23c. If ves. outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 I linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by hypertension, pieulous myoraidine infaction 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy dIJEAJR vascular perform certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA P 27. Manner of Death

1 X Natural
2 Accident 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division (Month, Day Year) 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

1041

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

SEP 0

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			For State of Maryland / State Registrar		tment of He ficate of D		ental Hygie	ne 200	7 28295
	Physicia	an	1. Decedent's Name (First, Middle, Last)				Date of Death     Month	Day Yea	3. Time of Death
	/Medic	al	Geraldine L. Martin  4a. Facility Name (If not institution, give street and number)		lh City Town or	Location of Death	August	27 200 4c. County of D	
	Examin	er	19 Washburn Avenue		Baltim			N/A	
- 0.5%	Funeral Director		5. Social Security Number  216 42 1294  6. Sex  1 □ M 2 □ F 7. Age (In yrs. last to 10 m 2 □ F 6.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. 1945 M	Birthplace (State or Foreign Country) [aryland
-	-ap		Usual Residence of Decedent         10a. State         10b. County         10c. City, To	own or Local	tion				10d. Inside City Limits
	//anyla f shov ed at	ō	1001 01010	timor					1 K Yes 2 □ No
	r 28a-	Director	10e. Street and Number	T	10f. Zip Code		10g	. Citizen of What	Country?
	ith witl 23a o ust be		19 Washburn Avenue		212			U.S.A.	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. It has a stream of the stream 23a or 28a-f show litem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		as Decedent of His /es, specify Cubar ] Yes 2 🙀 No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc. Vhite
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Maryland 2121	d within giene. er than ' the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Cashi	,	***		Reta	ail
and	be file ntal Hy ed oth event	Be	17. Father's Name (First, Middle, Last)  Robert Fritz				e (First, Middle, Ma a Watson	iden Surname)	
2	should nd Mer marke	욘		19b. Mailing	Address (Street a		a Watson al Route Number, C	City or Town, Stai	te, Zip Code)
	and 2 salth ar								aryland 21234
ore	Pages 1 and the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contr		1 Burial 2 Ucremation 3 Li Removal from State		ion (Name of tory or other place	9)		c. Location - City	
Baltimore,	permit. Pages : Department of H Important: If ite any injury or of		4 □ Donation 5 □ Other (Specify) Glen  21. Signature of Funeral Service Licensee		Mem. Pa	ark 8/31	/2007  G1 nce Funer		ice, Maryland
ñ	Der Jung					e Highwa	y Baltim	ore, Mai	ryland 21225
	Physician Physician		23a. P. nt. Enter the disease, or complections that caused the death. D cock, or heart failure. List only be lause on each line.  Immediate Cause (Final disease or condition	Do not enter	the mode of dying	g, such as cardiac	or respiratory arres	t, Klont	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  a.  Due to (or as a consequence)		OCH II	,,	2 1 - 7 - 0		
ħ.		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	es of).					
<b>b</b> :	xecuted and Il-transi	Examiner	Cause (Disease or injury that initiated events c	ce of):		·			
8760,	ate be executed thysician and the burial-transit	dical E	d						
9	ertificating physe as th	Medi	IF FEMALE:		-	1			
O. Box	The law requires that the death certificate be executed the law seen signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	23c. If yes, outcome pf pregnant in the past 12 months?  1	ath 3⊟E	ctopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
s, P.	N requires that the dipose signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting	g in the und	erlying cause give	en in Part I.			te to the cause of death?
Records,	requir		Mobil Shelly				1 ☐ Yes		Probably 4 Onknown
		Completed	probled Shelly				24a. Was an autopsy performe 1 Yes 2	prior deal	e autopsy findings available to completion of cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of th
Vital	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ Mo  Hospital: 1 ☐ Inpatient 2 ☐ ER/	/Outpatient	3D DOA Othe	>r.	h (Check only one) ome 5 Residen		Casaital
n or	Attending Physician: r death. ector, After this certificaby the funeral director,	ion: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	Bb. Time of Injury	28c. Injury Work		28d. Describe how		эреспу)
Division or	l or Attending Phys after death. Director: After this I in by the funeral dii	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	e, farm, stree		res Z No	28f. Location (Stre City or Town,		or Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b.	edical C	29a. Certifier  (Check only one)  Medical Examiner: On the basis of examination and manner stated.	edge, death on and/or inve	occurred at the tinestigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	use(s) and manne te and place, and	er as stated. due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		29c. License	e number	290	d. Date signed (A	Month, Day, Year)
		0)	· CC'NO		200	5506		08/3	0/2007
	4		30. Name and address of person who completed cause of death (Item 23:	a) (Type, Pi	rint)	et Bel.	famore.	Horse	land 2/225
		ate rar	31. Date filed (Month, Day, Year) SEP 0 5 2007 32. Registrar's Signature	of Age	adi'	in state.			fonth, Day, Year)  0 / 200 7  /end 2/225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10:15 A.M August Adam Frank Malinda /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Howard Ellicott City Ellicott City Health & Rehab. If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Months 1 X M 2 □ F 217 24 6618 79 1928 Maryland Aug. 18. **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County 10a. State 1 ☐ Yes 2 X No Director Ellicott City Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or Items 23a or dical Examiner must be U.S.A. 3000 North Ridge Road 21043 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: Korean 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 X No þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Medical College (1-4or 5+) Elementary/Secondary (0-12) Nat'l Security Agency Electrical Engineer the permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If item 27 is marked other in any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Malinda Agatha Tokarski ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Millersville, Maryland 21108 314 Songwood Court Katherine Malinda / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MD. State Veteran Cem.9/4/2007 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Lie 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final urinany tract **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner End stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Von healing burial-trar Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∏ Yes Hospital or Attending Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗀 Yes Medical Certification: To this 27. Manner of eath funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) Injury 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by determined 4 ☐ Homicide 24 hours a e Funeral I tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 24 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

11

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

E ( ) and

D30641

August 31 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) River Nick Road 13altimore Maryland 21221

31. Date filed (Month, Day, Year) SEP 0 5 2007



07-06720 Lisa A. Madej

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 28297 Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day August 29, 2007 Physician/ 1816 hrs Α. Madej Lisa I Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie Baltimore Washington Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 09/15/1966 Country) Director 40 MD 212-86-5565 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any 1 Yes 2 X No 28a-f show Maryland Anne Arundel Pasadena Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number USA 21122 765 207th Street 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Examiner must be Armed Forces? 1 Never Married Yes 9 White Yes 2 X No specify: f Yes, Give Year Widowed Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work-done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) timore, MD 21215-0036

1. Pages I and 2 should be filed within 72 hourment of Health and Mental Hygiene
Transmit. If iten 127 is marked other than "na range or other transmatic event, the Medical Exp . Elementary/Secondary (0-12) College (1-4 or 5+) Household Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Ε. Colhouer Jeanette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnnt) 765 207th Street, Pasadena, (husband) Christopher J. Madej 20b. Place of Disposition (Name of cemetery, Date ltimore, Burial 2 Cremation 3 Removal from State crematory or other place) Sept. 04 2007 Department of Important: J Meadowridge Cemetery Elkridge Maryland Donation 5 Other Specify Name and Address of Facility Stallings Funeral Home 3111 Mountain Road, Pasadena, IID 21122 22. Name and Address of Facility . 21 Signature of Funeral Service Acenses ised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-Approximate Interval Part I. Enter the disease, or complications that ca Between Onset and hysician failure. List only one cause on each **Medical** a Multiple Injuries Immediate Cause (Final disease ≟xaminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transit the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and Physician/Medical UNPENDED AMENDED 23d. Date of delivery Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE: Year Day Month 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 1 Yes 2 V No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available Division of Vital Records, 24a. Was an his certificate has been director, page 2 should autopsy prior to completion of cause of death? performed? 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Other₄ Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 DOA 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury 27. Manner of Death Driver auto fixed object collision Aug 29, 2007 Certification 1713 hrs Yes 2 🗸 No Natura Pending filled in by the f 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide or Town, State) Creek Road at Lake Road, Pasadena, MD determined (Specify) Local Street Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 30, 2007 O.C.M.E. Dome mornert. IMID. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD 31. Date filed (Month, Day, Year) State

Registrar

SEP

Certificate of Death

Reg. No 2007

2007

BALTIMORE

USA

WHITE

SANDLER

14. Race - American Indian.

Black, White, etc.

23d. Date of delivery

31/2007

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

**≫** No

Day

2. Date of Death

28298

11:07 A

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits

1 ☐ Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. pistrar's Signature

MICITELION

2007

Year)

31. Date filed (Month, Day,

1. Decedent's Name (First, Middle, Last)

**Physician** 

Registrar DHMH 17 Rev 1/2001

State

750 Mainstreet Keisterstown, MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 28299 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Franklin Delano Roosevelt Neely 30 2007 2:00p August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 213-32-9329 Director Jan 8 1936 VA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Carrol1 Sykesville 1 ☐ Yes 21 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 Rockvale Road 21784 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 □ No 1954-If Yes, Give Year or Dates: 1958 1 ☐ Never Married 2 ☐ X Married 1 ☐ Yes 2 ☐ No Specify: white ģ 3 Widowed 4 Divorced 1958 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) salesman bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luther Neely Catherine Louise Burke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel M. Neely (spouse) 111 Rockvale Rd., Sykesville, MD 21784 item 27 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of He Important: if iten any Injury or oth once. 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 9-4-07 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses ▶ Page Haight Sperbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Peritonitis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine physician and s the burial-trans Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pueumonia 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Emplythina 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2K No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, ours after death.
neral Director: A
filled in by the fu within 24 hours a

To the Funeral C

completely filled

Baltimore, Maryland 21215-0036

Certification: To 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of dertifier 29c. License number

D46052

29d. Date signed (Month, Day, Year) 8/31/07

30. Name and address of person who completed cause of death (Item 23a) Type, Print on kway

State Registrar

31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene,

,	2	8	3	0	0

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** SEPTEMBER 02, 2007 24:40FM Evangeline Priscilla /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Towson 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 ☐ M 2 💢 F 66 July 26,1941 553-56-9934 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 🕅 No Director Mη Baltimore Reisterstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code o e ns 23a c must b 234 Highmeadow Road 21136 USA Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If them 27 is marked other them any injury or other trainments. items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ▼ No Specify. Specify: þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Albert Garcia Genevieve Vigil 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 234 Highmeadow Road, Reisterstown, MD 21136 <u>William L. Olson</u> Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 9/7/07 Owings Mills, MD 21. Signature of Funeral Service Lic 22. Name and Address of Facility 11824 Reisterstown Road Adults u Eline Funeral Home Reisterstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ANOXIC ENCEPHALOPATHY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CARDIAC ARREST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of): Examine The law requires that the death certificate be executed MYOCARDIAL INFARCTION resulting in death) Last Due to (or as a consequence of): Box 68760, physician s the buria CORONARY ARTERY DISEASE Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1☐ Yes 2 No Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown MULTIPLE SYSTEMS ORGAN FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an as 3 2 s certificate ha 1□ Yes 2 X No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Description** In the date and place and place and place, and due to the cause(s) and manner stated.

**Description** In the date and place and place and place and place and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certific D24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOW, 7601 OSLER DRIVE TOWSON. TIMOTHY M. D. 2. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

Pay (Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #8, perFH, C871, 9/11/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4b. City, Town, or Location of Death **Examiner** 8. Date of Birth (Month, Day, Mar. 7, State or Foreign **Funeral** Months 1 □ M 2 I 1950 Director Decedent with the Maryland 10d. Inside City Limits 10c. City: Town or Locatio ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Blac þ 3 Widowed 4 ☐ Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done life, DO NOT use retire Elementary/Secondary (0-12) College (1 17. Father's Name (First, Middle, Be ပ 20a. Method of Disposition 2 Cremation 1 🔲 Burial 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur 23a. Part 1. Enter the di shock, or heart or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consiquence of) Examiner Sequentially list conditions, in the limit of the limit of the list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 200 No 3 ☐ Probably 4 ☐ Unknown has been si re 2 should 1 Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page certificate 1□ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: P 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4XXNursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director: A completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

10

Registrar

State

30. Name and

31. Date filed (Month, Day, Year)

0 5 2007

of death (item 23a) (Type, Print)

Ragistrar's Signature

			For State Registrar	State of I	Marylar		artment of F rtificate of		d Mental Hy	giene	007	28302
	g tible sec	767	Decedent's Name (First, Middentification)	dle, Last)					2. Date of D	eath		3. Time of Death
П	Physici /Medi		Patric	ia Lynch Pr	ice				Month Augus	t 28	, 2007	3:30a [™]
	Examir		4a. Facility Name (If not institution	on, give street and number	er)		4b. City, Town, o	r Location of D	eath	4c.	County of Deat	
3		(A)		n Spring Ave			Owings				altimor	
	Funeral Director		5. Social Security Number 219–18–8289	6. Sex 7. 1 □ M 2 ☑ F		last birthday,	If Under 1 Year Months Days		Hrs. 8. Date of Bi Win. (Month, D March 1	ay, Year)	Co	hplace <i>(Stat</i> e or Foreign wintry) kesville, MD
	land w t		Usual Residence of Decedent  10a. State 10b. Count	ty	10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits
	Maryl -f sho ied a	호	MD Balt	imore Co.	Ow	ings M	iills					1 □Yes 2 No
	r 28a notif	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Co	ountry?
	th with		11920 Gree	n Spring Ave	2		21117			USA	A	
	ems er mu	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U s?	.S. 13.	Was Decedent of H	lispanic Origin an, Mexican, P	? (Specify Yes or N uerto Rican, etc.)	0- 1	14. Race - Ame Black, White	
Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show atic event, the Medical Examiner must be notified at	β	1 ☐ Never Married <b>2 </b> Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes, Give	_		1 ☐ Yes 2 ☐ No	Specify:	,		Specify: wh	•
2	72 hc 'natu dical	etec		ent's Education lest grade completed)		1 (Give	dent's Usual Occup kind of work done	during most of	working	16b. Kir	nd of Business/	Industry
7	vithin ine. ihan '	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)	1	011 cleri	*	-	LIO.	stern E	lootmio
'n	iled v Hygie ther t		12 17. Father's Name ( <i>First, Middle</i>	a Last)		layı	oir cierr		Name (First, Middle			rectric
and	should be filed nd Mental Hygi marked other matic event, t	) Be	William Jos	•					rude Andr	•	ourname,	
$\overline{\leq}$	should Me mark mark	ဂ္	19a. Informant's Name/Relation			19b. Maili	ng Address (Street	L	r Rural Route Numi		r Town, State, 2	Zip Code)
S	nd 2 suffith au 27 is rtrau		Howard Cal	vin Price -	husba	1						ls, MD 21117
ē,	s 1 a		20a. Method of Disposition			Place of Disponent	osition (Name of matory or other place	1	Date		cation - City or	
altimore,	Page nent c int: If		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		ie		dge Cem.	- 1	1/07	Pike	esville	, MD
a	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev once.		21. Signature of Funeral Service	e Licensee		2	2. Name and Addre	ess of Facility	11	824 F	Reister	stown Road
<u> </u>	8 9 E 8 9		Jans &	Cine			Eline Fur		ome Re	ister		MD 21136
п			23a. Part1. Enter the disease, of shock, or heart failure. Lis	st only one cause on eacl	ı line.				50	arrest,		Approximate Interval Between Onset and Death
	Physician		disease or condition resulting in death)	a	5-	trolu	tia	ettra	le le			Geans
	/Medical Examiner		resulting in deathy	Due to (or	as a consec	uence of):	tic					years
		<u>~</u>	Sequentially list conditions,	b	98 9 CUNBBO		9 1a					Jan 3
	nted nnsit	اچّا	Sequentially list conditions, and any localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<								
Ć,	icate be executed physician and s the burial-transit	Examiner	resulting in death) Last	C Due to (or	as a conseq	juence of):						
8760,	te be ysicia ie bur	dical		d								
9		ledi	IE CEMALE.									
Box	leath certific attending p I for use as	an/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1 ☐ Live birth	ne pf pregna 1 2 ☐ Feta		☐Ectopic pregnancy	y		2	3d. Date of del	ivery Day Year
	e dea the at ned fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnan 9□Unknowi		death 5[	Other (specify)				MOUL	Day real
Records, P.O	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	by Physician/Me	Part II. Other significant condit	tions contributing to deat	hut not res	ulting in the u	nderlying cause giv	en in Part I	23e. Did	tobacco us	se contribute to	the cause of death?
g,	signe d be o		Hupe		•		,g g					robably 4 □Unknown
Ö	w require been sign	etec	Nessa	Thyroi	11 10			-	24a. Was	000	24b Word ou	utopsy findings available
Æ	he lav e has ige 2 :	Completed	profes	, rugion	A   J	_			— auto	psy ormed?	prior to death?	completion of cause of
Vital			25. Was case referred to medic	al				26 Place of	1  Yes  Death (Check only	2 No	1 ☐ Yes	2 No
	ysicle s cert direct	o Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa	atient 2	ER/Outpatie	nt 3□ DOA Oth	or.	ng Home 5 Res		□ □Other (Soe	cify)
Division or	rding Phys h. : After this funeral dir		27. Manne eath	28a. Date of I		28b. Time o			28d. Describe			
Ö	Attendin death. octor: Aff y the fur	atio	Z L Accident	tigation	Day rear)	Injury		Yes 2 □ No				
<u>S</u>	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined   266. Place of	injury - At h etc. <i>(Sp</i> ec <i>i</i> i	ome, farm, st fy)	reet, factory, office			(Street and wn, State)		ural Route Number,
	ital o Irs aff ral D								ú.		<u> </u>	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, i	Medical	29a. Certifier 1 Certify (Check only one) 2 Medica	ring Physiclan: To the be al Examiner: On the basi and manner	s of examina	owledge, dea ation and/or in	th occurred at the tile tile tile tile tile tile tile til	me, date and p opinion, death	place, and due to the occurred at the time	cause(s) , date and	and manner as place, and due	s stated. e to the cause(s)
	o the ithin 2 o the	Med	29b. Signature and title of certifi		stated.		29c. Licens	se number		29d. Date	e signed (Mont	h, <b>Da</b> y, Year)
	F 3 F 8		> Ala		0 2	un	72	r7+	3		6/76	107
,	10		30. Name and address of perso	n who completed cause of	f death (Iter	n 23a) (Tvne.	Print)	7 , 0 ,			1 4	101
	10		Alan Kimm	elmo	1051	9 N	orth Ch	ales	St B	alt	Md	21204
	Sta		31. Date filed (Month, Day, Year	r) 32. Regi	strar's Signa	ature			1			
L	Regist	rar	SEP OF	2007	2		-					
DF	IMH 17 Rev 1/2	100	201 00	- CO : July State of	الناكر مسأ	1000	Sec.					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** PIKE RICHARD 1:10 PM August 2007 30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BAITIMORE HOSPITAL N/A HARBOR 8. Date of Birth (Month, Day, Year) March 26,1947 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 F 60 234 72 6500 Director West Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ▼No Maryland Anne Arundel Baltimore Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 711 Cresswell Road 21225 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
int: If Item 27 is marked other than "natural", or itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. White Specify: 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Safety Engineer years Construction Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Pike Sr. ٩ Mary (unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carolyn Kelly / Fiancee 711 Cresswell Road Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/1/2007 Bayview Crematory 4 Donation 5 Dother (Specify) Baltimore, Maryland 21. Sign fun of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Tuna nominelle 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Set only one cause on each line. Immediate Ceuse (Final HEPATIC ENCEPHALOPATHY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner GASTRO INTESTINAL BLEEDING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner HYPER COAGUIIBELITY signed by the attending physician and it be detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1□Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1□ Yes 2□ No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral

Medical 29b. Signature and title of certifier Sparle

29a. Certifier

SAIRAH BASH R C. License number Doctor

RES001

29d. Date signed (Month, Day, Year)

August 30,07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARYLAND SOUTH HANOVER STREET, BAITIMORE 21225 Harbor Hospital

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month) 2007 CASULA ...

M

**Funeral** Director

a.m.

2007 1:15

AUGUST 30,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Furneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, PEARSON, JOSEPH

For State of Ma	-		cate of D		R	eg. No. <b>2</b>	007	2830
1. Decedent's Name (First, Middle, Last)  JOSEPH WILLIE PEARSON					2. Date of Dea Month AUG.	Day	Year 007	3. Time of Death
a. Facility Name (If not institution, give street and number) STELLA MARIS HOSPICE		4b.	TIMO			_	unty of Death	
217-68-4717 1 [™] 2□F	(In yrs. last birt	Yrs. If U		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 5/19/1	pate of Birth Month, Day, Year) 5/19/1958 9. Birthplace (Str Country) MARYLAN		lace (State or Foreig try) YLAND
Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   MD   N/A   BALTIMORE CITY								
10e. Street and Number 10f. Zip Code 10g. Citizen of Wi								1 DXYes 2 □ N try?
815 E. 34TH STREET  1. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced  1. Marital Status 1 XNever Married 2 Married 1 X Yes 2 □ W If Yes, Give Year or Dates:	Ever in U.S. Io US ARMY			panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14.	JSA Race - Americ Black, White, ecify: BLA	etc.
15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  17 DRIVER  16b. Kind of Busines (Give kind of work done during most of working life. DO NOT use retired)  17 TRANSPORT								·
7. Father's Name (First, Middle, Last) THOMAS SHIELDS			1	8. Mother's Name	e (First, Middle, I IE MAE E		,	
19a. Informant's Name/Relationship (Type. Print)  WILLIE MAE ALLEN / MOTHER	ı	-	-	STREET,				Code)
0a. Method of Disposition  1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of cemeter	Disposition y, crematory	(Name of or other place) FORES!	)	Date	20c. Locati	on - City or To	
1. Signature of Funeral Service Licensee	Non		ne and Address	of Facility H	OWELL FU			21207 E. MD
Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last    Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)  Month								ery Day Year
art II. Other significant conditions contributing to death bu	ut not resulting in	the underly	ing cause given	in Part I.			contribute to th	ne cause of death?
						sy med? 2 <b>∑</b> No	prior to cor death?	psy findings availab npletion of cause o 2□ No
5. Was case referred to medical examiner?  1 □ Yes 2 □ No  7. Manner of Death 1 □ Notural Simple Pending investigation 3 □ Suicide 4 □ Homicide  5. □ Pending investigation 6. □ Could not be determined  28e. Place of injure building, etc.	y 28b. T	Time of njury M	DOA Other  28c. Injury a Work? 1 Ye	4 L. Nursing Ho	h (Check only or ome 5 ☐ Resid 28d. Describe h 28f. Location (S City or Tow	ence 6 vo	curred	
29a. Certifier (Check only one)  1 Certifying Physician: To the best of Medical Examiner: On the basis of and manner sta	examination and	e, death occu d/or investig	urred at the time ation, in my opi	e, date and place, nion, death occur	and due to the o	ause(s) and date and pla	d manner as stace, and due to	tated. the cause(s)
9b. Signature and title of certifier			29c. License	number +3775		29d. Date si	gned (Month,	
30. Name and address of person who completed cause of de DR. TARIQ MAHMOOD 230	0 DULAI ar's Signature		D	+3725		8	30(0	7

Stat Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 30 per plant of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** POISK 2/10PM Esther 30 August 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GOOD SAMARITAN HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Y 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 06/30/1919 1 □ M 2 F Days Hours 88 119-01-5500 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: if item 27 is marked other than "natural", or items 23a or 28a-f show unt; if item 27 is marked other than "natural", or items 29a or 28a-f show unty or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 No Funeral Director N/A BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21239 1601 E. BELVEDERE AVENUE 14. Race - American Indian, 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Completed by 3 Nidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **CLERK** U.S. GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **ROSE** KLEIN SAMUEL WEINREB 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 ARIEL LOOP, HENDERSONVILLE, permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tra STEPHANIE MARSH / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place)
RODFE ZEDEK 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE, MD 09/02/2007 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Urosepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed buriai-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 1 No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 dunknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe 25. Was case referred to medical exampler? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mapner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation 1 🗹 Natural 1 ☐ Yes 2 ☐ No n 24 hours at er death.

Pe Funeral Director: A pletely filled in by the fi 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Del 6008 August 30, 2007

27 ×30

State Registrar Kathleen D. Keeffe ate filed (Month, Day, Year)
SEP 0 5 2007

5601 Loch Raven Blvd. Baltimore, Md. 21239–2995

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 egistrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

07-06849	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
Michael Sean Quental	State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certifica	ate of Death	Reg	. No. 2007 2830			
Physiciaı Jedical Examin	n/ er	Decedent's Name (First, Middle, Last)     MICHAEL SEAN QUENTAL		2. Date of Death Month September	3. Time of Death			
		Facility Name (if not institution, give street and number)     String Richards Court	4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore County			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 1218~13~1266 1X M 2 F 27	Months Days Hours Mir	_	(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD.			
Maryland 28a-f show any d at once.	jo		or Location ltimore County	w	10d. Inside City Limits 1 Yes 2 XXNo			
h the Maryland 23a or 28a-f sho		10e Street and Number 19 King Richards Ct.	10f. Zip Code 21237		Clitizen of What Country?			
er death wit	Funera	11. Marital Status  1 XX Never Married  2 Married  3 Widowed  4 Divorced If Yes, Give Year	13. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.			
"natu	eted by	15. Decedent's Education (Specify only highest grade completed) 16a. I	1 Yes 2 XX No specify: Decedent's Usual Occupation (Give kind of luring most of working life, DO NOT use ret	work done 1	Specify: White 6b. Kind of Business/Industry			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other tranmatic event, the Medical		12th grade N/A Col 17. Father's Name (First, Middle, Last)		(First, Middle, Ma				
2121; hould be fil and Mental I is marked rtic event,	9		. Mailing Address (Street and Number or		er, City or Town, State, Zip Code)			
re, MD 2 s 1 and 2 shoul of Health and N If item 27 is n er fraumatic	L	20a. Method of Disposition 20b. Place o	19 King Richards Ct.  Disposition (Name of cemetery, ry or other place)		Pre, Md. 21237  20c. Location - City or Town, State			
Baltimore, bermit. Pages I ar Department of Hee important: If ite		4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee	Crematory 9-7    22 Name and Address of Facility   1   1   1   1   1   1   1   1   1		Baltimore, Md.			
Physician	8	23a. Part I. Enter the disease, or complications that caused the death. Do no failure. List only one cause on each line.	/401 Belair Rd. E	Baltimore				
/Medical xaminer	1		eumonia complicating coc	aine & metl				
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	) Treat	+.4				
\ X	ТХа	(Disease or injury that initiated events resulting in death) Last    Due to (or as a consequence of):  d.						
i760, ficate be executed g physician and the burial - transit		X UNPENDED  AMENDED, #23a, 27, perME, g873,  IF FEMALE:  23c. If yes, outcome of pregnancy	11/6/07 TT		23d. Date of delivery			
Box 68's death certificate attending and for use as	Sician	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  1 Unknown  2 Unknown	Fetal death 3 Ectopic pregna Other (Specify)	ancy	Month Day Year			
, P.O. E	2	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		acco use contribute to the cause of death?  2 No 3 Probably 4 Unknown			
Division of Vital Records, P.O. Box 68  Hospital or Attending Physician: The law requires that the death certif 42 hours after death.  Funeral Director: After this certificate has been signed by the attending lety filled in by the funeral director, page 2 should be detached for use as a formal of the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the fune	Completed			24a. Was an autopsy perform	ed? death?			
ital sician: s certi	e e	25. Was case referred to medical examiner?	26.Place of Death (Check					
n of Vi		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. T	tpatient 3 DOA Ourel 4 Nursin ime of Injury 28c. Injury at Work?	28d. Describe how	esidence 6 🗹 Other: Scene w injury occurred			
Division o Hospital or Attending 24 hours after death. Funeral Director: After	etillicat	Accident Accident Suicide Homicide Accident Suicide Accident Accident Suicide Accident Suicide Accident Suicide Accident Suicide Accident Accident Suicide Accident Accident Suicide Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident A						
29b. Signature and title of certifier 29b. Signature and title of certifier 3 certifier 3 certifier 4 certifier 4 certifier 5 certifier 5 certifier 6 certifier 7 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as start and manner stated.  29b. Signature and title of certifier 7 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as start and manner stated.  29b. Signature and title of certifier 7 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner as start and manner and manner and manner as start and manner as start and manner as start and manner and manner and manner and manner as start and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manner and manne								
		29b. Signature and title of certifier	29c. License number O.C.M.E.		9d. Date signed <i>(Month, Day,</i> Year) September 4, 2007			
\$		30. Name and address of person who completed dause of death (Item 23a)  Tasha Greenberg MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MI	21201				
Stat	е	31. Date filed (Moeth Day Year) 2007 31. Registrar's Signature	Davie .					

07-06733 Vernon Robinson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ernon Robinson	1- For State	yland / Department of Certificate of		/giene Reg. No	2007 2830
Physician/	1. Decedent's Name (First, Middle,Last)			Date of Death     Month Day	3. Time of Death
edical Examine	Vernon A. Robins		4. City Tayre and eastion of Dooth	August 30, 20	4c. County of Death
	4a. Facility Name (if not institution, give street an 4904 Alson Drive	i number)	b. City, Town, or Location of Death Baltimore		N/A
Formal	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	. 8. Date of Birth(MI	M/DD/YYYY) 9. Birthplace (State or
Funeral Director	216-86-1142 1 XM 2		Months Days Hours Min.	10/12/	1968 Foreign Country) Md.
	Usual Residence of Decedent			10/12/	
any.	10a. State 10b. County	10c. City, Town or Locat	ion		10d. Inside City Limits  1 X Yes 2 No
aryland 8a-f show at once	Md. N/A	Baltimor	re		
tor 28a-f shiffed at once	10e. Street and Number		10f. Zip Code		Citizen of What Country?
			21201		SA 14. Race - American Indian, Black,
r death with or items 23 must be no	11. Marital Status  1 X X Never Married 2 Married Armi	ed Forces? If Y	as Decedent of Hispanic Origin? (Sec., specify Cuban, Mexican, Puerto	Rican; etc.)	White, etc.
or dear	1 Yes, Giv		Yes 2 X No specify:		Specify: Black
"natural" Examine	Tor Dates:	grade completed) 16a. Deceder	nt's Usual Occupation (Give kind of		b. Kind of Business/Industry
	Elementary/Secondary (0-12) Colle	ge (1-4 or 5+) during m	nost of working life. DO NOT use ret		group tips 4 to 5 form . Some a long is to a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a long it is a
215-0036 be filed within 72 hours tall Hygiene rked other than "natuent, the Medical Example of Commisted.	12	Man	ager		Fast Foods
5-0 led w Hygie other				e (First, Middle, Maid	
21215-0036 21215-0036 Mental Hygiene marked other than e event, the Medical	Luther Robinson  19a, Informant's Name/Relationship (Type, Print	19h Mailin	g Address (Street and Number or	e Mae Je:	
0	Luther Robinson	· 1			Baltimore, Md. 2120
mnd 2 sho (ealth and ten 27 is traumat	20a. Method of Disposition	20b. Place of Dispo	sition (Name of cemetery,	Date 20	Oc. Location - City or Town, State
lore ges 1 it of H it If i		val from State crematory or o		8/2007 T.	ansdowne,Md.
Baltimore, permit. Pages I at Department of He Important: If ite	4 Donation 5 Other Specify:	W.C. Z.1011	Name and Address of Facility	Funoral	Home DA
Ba perm Depa Imp	Thousa III. S	5 (00) 1	Name and Address of Facility Step Brothers 300 Eutaw Plac	ce, Balt	imore, Md. 21217
Physician	23a. Part I. Enter the disease, or complications failure. List only one cause on each line.	hat caused the death. Do not enter	the mode of dying, such as cardiac	or respiratory arrest,	Between Onset and
'Medical aminer	Immediate Cause (Final disease a Hangin	g	1,0		Death
aiiiiiei	or condition resulting in death) Due to (o	as a consequence of):			
	Sequentially list conditions, if any, leading to immediate Due to (o	as a consequence of):	v .*	salt de	
ted Insit	(Disease or injury that initiated				
ed usit	events resulting in death) Last Due to (d	r as a consequence of):			
be executed iician and urial - transit	UNPENDED AMEN	DED			
50, te be e	IF FEMALE: 23c. If	yes, outcome of pregnancy			23d. Date of delivery
Box 68760, c death certificate but the attending physical for use as the but	23b. Was decedent pregnant in the	Live birth 2	etal death 3 Ectopic pregi	nancy	Month Day Year
Sox 6 leath ce e attend for use	1 Yes 2 No 9 Unknown g	Pregnant at time of death 5	Other (Specify)		
that the dened by the detached for	Part II. Other significant conditions contribu		underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
P.O. es that the gened by be detac	<u>a</u>	•		1 Yes	2 No 3 Probably 4 Unknown
cords, F				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
COF				performe	ed? death?
tal Rections: The certificate			26.Place of Death (Chec		V 110
Fital Sician sician is cert lirecto	examiner? Hospital:	Inpatient 2 ER/Outpatie	nt 3 DOA Other Nurs	sing Home 5 Re	esidence 6 🗸 Other: Scene
	0 1 ✓ Yes 2 No 28a 22. Manner of Death	Date of Injury 28b. Time o	f Injury 28c. Injury at Work?	28d. Describe how Subject hange	
on cendin ath.	1 Natural 5 Pending Au	(Month, Day Year) g 30, 2007	1 Yes 2 ✔ No	1. 1	
Division tal or Attendius after death. Tal Director: Alled in by the fu	2 Accident Investigation  Suicide 6 Could not be	. Place of Injury - At home, farm, st	reet, factory, office building, etc.	28f. Location (Street or Town, State	eet and Number or Rural Route Number, City te) ye, Baltimore, MD
Division  To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the	4 Homicide determined (S	ecify) Multi-Family Apt.		-	No.
D  To the Hospital within 24 hours To the Funeral completely filled		ne best of my knowledge, death occ basis of examination and/or investig	curred at the time, date and place, a	nd due to the cause() d at the time, date an	s) and manner as stated.  Indicate to the cause(s)
To th withir To th compl	and ma	nner stated.	29c. License number		29d. Date signed (Month, Day, Year)
	29b. Signeture and title of certifier	.111	O.C.M.E.		August 31, 2007
	30. Name and address of person who complete	of cause of death (Item 23a)			
		edical Examiner 111 Per	nn Street, Baltimore, MD 2	1201	
Sta	te 31. Date filed (Month, Day, Year)	32: Registrar's Signature			

Registrar

			State of Maryland / Department of Health and per dr., g871,09/05/07/dbb of Death	Mental Hygier	2007 28308
	Dhysisi		1. Decedent's Name (First, Middle, Last)	2. Date of Death	Jay Vear
jë Nje	Physici /Medi		Lucy R. Roe	Hugust	17, 2008 11:10 AM
	Examir	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deat	h	4c. County of Death
-			St. Elizabeth's Nursing Home Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	- 8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		219-16-6797 1 TM 2 TF 104 Yrs. Months Days Hours Min.	(Month, Day, Yes	1000
	P _		Usual Residence of Decedent	May 11,	
	r 28a-f show	_	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1X Yes 2 □ No
	18a-f	Director	Maryland N/A Baltimore 107 Zio Code	1.0	
	with t	ā	2220 Barrage Assa		Citizen of What Country?
	ter death w Items 23a	Funerai	11 Martial Chatus 12 Was Decedent Ever in LLS 13 Was Decedent of Hispanic Origin? (5		JSA 14. Race - American Indian,
36	a o E	by Fun	1 Never Married 2 Married   Armed Forces?   If Yes, specify Cuban, Mexican, Puer   1 Yes 2 No   to Rican, etc.)	Black, White, etc.  Specify: White	
Maryland 21215-0036	"natural",		15 Decedent's Education 16a Decedent's Usual Occupation	16b	. Kind of Business/Industry
215	c * @	Completed	(Specify only highest grade completed)  (Give kind of work done during most of wo life. DO NOT use retired)  Elementary/Secondary (0·12) College (1-4or 5+)	rking	
7		Co	Cook	me (First, Middle, Maid	estuarant
and	be d la la la la la la la la la la la la la	Be	I al II D 1 '		
ž	2 should be f and Mental h is marked of raumatic evs	٦	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ri	te Robinsor	
<b>⊠</b>	rd 2 s lith an 27 is :		Patricia Holsey 6 Arkla Court Ca		
ē,	ges 1 and 2 should t of Health and Mer If Item 27 is marke or other traumatic		20a. Method of Disposition 20b. Place of Disposition (Name of		Location - City or Town, State
E 0	Pages ent of nt: If I		1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Meadowridge Memorial Parl	× 08 <b>-</b> 22-07	Elkride, MD
Baltimore,	permit. Pag Department Important: Il any Injury o		21. Signature of Euneral Service Licensee  22. Name and Address of Facility Ambrose Funeral E		-2.12.2030, 1.20
	40.240	$\dashv$	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	ing Rd. Art	outus, MD. 21227
	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   — Due to (or as a consequence of):		
	1994	e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	and I-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events		
90,		EX	resulting in death) Last Due to (or as a consequence of):		
68760,	cate phys the	edicai	d		
P.O. Box 6	death certii e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▷ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of delivery Month Day Year
	requires that the een signed by thi nould be detache	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
ord	w requir been si should I			1 🗆 Yes	2 No 3 Probably 4 Unknown
Division of Vital Records,	The law ste has b page 2 st	Completed		24a. Was an autopsy performed 1 Yes 2	
<u> </u>	Physician: Tribis certificer	Be	examiner?	ath (Check only one)	
of	Phys rrthis aral di	7	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	dome 5 Residence	
ion	Attending I r death. ector: After by the funer	atior	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No		
N.	after death after death Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	and Number or Rural Route Number,
٥	ital or rs afte ral Dir led in	Cer	building, do. (opeany)	ony or rown, or	
	To the Hospital or Attan Within 24 hours after deat to the Funeral Director: completely filled in by the	edicai	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical examiner and manner stated.	e, and due to the cause urred at the time, date :	e(s) and manner as stated. and place, and due to the cause(s)
	within 2 To the complet	Me	29b. Signature and title of centier 29c. License number	29d.	Date signed (Month, Day, Year)
			· / C W 052 190	a lu	us., 18, 2001
(	8)		29b. Signature and title of pentier  29c. License number  252 796  30. Name and address of person who completed cause of death (Item 23a) (Type, Priot)  Yelena hone W 720 Menden Choice C	are so	elf un 21225
	Sta Registi	te	31. Date filed (Month, Day, Year) SEP 0 5 2007 32. Registrar's Signature		

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Stonesifer September 3, 2007 Arlene Sharon 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 5725 Emory Road Upperco If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number 1 □ M 2√2 F Yrs. 54 212-62-4523 April 15,1953 Baltimore, MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Baltimore Upperco 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5725 Emory Road 21155 USA 14. Race · American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernard D. McVicker Ruth Gover 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ralph L. Stonesifer Husband 5725 Emory Road, Upperco, MD 21155 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gard. 9/7/07 Finksburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road 21136 Approximate Interval Between Onset and Death

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

þ

Completed

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar manage.

burial-tran use Por completely filled in by the funeral

The law requires that the death certificate be executed

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Division or Vital Records, P.O. Box 68760,

Certification:

1 Tes

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a, Certifier

31. Date filed

4 ☐ Homicide

29b. Signatule and title of certifier

5 Pending investigation

6 Could not be

determined

Year) 2007

	-500	Eline Fun	eral Home Keisterst	.own, MD	21130
dical Examiner	23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	bomplications that caused the death. Do not enter the mode and only one cause in each line.  a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.	ring, such as cardiac or respiratory arrest,		Approximate Interval Between Onset and Death
ysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 3 □ Ectopic pregnan 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of de Month	elivery Day Year
npieted by Pri	Part II. Other significant condition	ns contributing to death but not resulting in the underlying cause g	given in Part I. 23e. Did tobac  1 ☐ Yes  24a. Was an autopsy performed	2 No 3 F	to the cause of death?  Probably 4 Unknown autopsy findings available completion of cause of
20	25. Was case referred to medical	2	1 Yes 2 26. Place of Death (Check only one)		s 2 No

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

3□ DOA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 □ Yes 2 □ No

1 Inpatient

(Month, Day Year)

28a. Date of Injury

Registrar DHMH 17 Rev 1/2001

State

Medical

State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month Year **Physician** 2:12 PM SEMEN 32 Estender 3 2047 SHICOVITSICI. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 21133 4b. City, Town, or Location of Death Examiner Banker 1 Towns MO Normwert HUST- JUE ante If Under 1 Year II Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 € M 2 □ F Yrs 86 Director Aug. 27, 1921 Russia 214-41-6711 Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Iteme 23a or 28e-f ehow the Madical Examiner count be notified at 1 ☐ Yes 🎗 ☐ No by Funeral Director MD Reisterstown Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Brookebury Drive 1A21136 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Doctor .. Peges 1 and 2 should be filed v tment of Health and Mental Hygie tant: If Hem 27 te marked other t jury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bluma Moisey Shilovitskiy unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Yelena Shilovitskaya Daughter 104 Caraway Road, 2C, Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pege Department o Important: If eny Injury or once. Hampstead, MD Carroll Cremation 21. Signature of Euneral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Medicin Eline Funeral Home Reisterstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Arterpoidenti Carch July cutacur /Medical Due to (or as a consequence of): Examiner Presenvia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner g physicien and as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown ete hes been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 ☐ Yes 2 No Division of Vital : After this certificel funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ № 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) ۽ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9/3107 D18313 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 000 Court 120. RAPPL SAMPING RANGELINA MO 21137

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) SEP 0 5 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 24a-b, perMD, g871, 9/5/07 TT Certificate of Death Reg. No 2. Date of Death Month Day Physician 1515 PM Starkes Martha Auc 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mercy 5. Social Security Number medical Center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Year) Months 1□M 2♥F 04 74 10 33 Director 214-38-7010 Usual Residence of Decedent MD 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at ty∐Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Examiner must be items 23a U.S.A.

14. Race - American Indian, death 1 4105 Belvieu Ave 21215 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after rent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☑ Married ö 3altimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify If Yes, Give Year or Dates: Completed by Black 3 Widowed 4 Divorced 'natural', the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland 12th grade na Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ or other traumatic Howard Jackson Ellen Freeman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles Starkes-Son 10200 Cascade Falls Ct, Owings Mills, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of I-Important: If ite any injury or ot Burial 2 Cremation 3 Removal from State King Memorial Park 8/30/07 Randallstown, md 21. Signature Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 3a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho x, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediare Cause (Final sease or condition resulting in death) Physician Aspiration Preumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Lisass or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. physician the use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ binknown certificate has t een s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an nerform 1X Yes 2X No or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3*0*0' 21 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Be Raltmore MD 301 St. faul Place 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

07-06637

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2007 28312

Glen	Michael Ste		t State	of Maryland /		ment of <i>ficate of</i>		and N	/lental Hy		_ U	0/ 2031
	· ·	<u>F</u>	Registrar  1. Decedent's Name (First, Middle,Las	t)	- Certin	icate or	Dodan		2	Reg. I		3. Time of Death
M	Physicia ' Examir			.,			Stew	- w t-		Month Da August 27, 2	ov Year 007	0208 hrs
(			Glen 4a. Facility Name (if not institution, give	e street and number)		4	b. City, To	vn, or Loc	ation of Death		4c. County of Dea	
			Queen Anne Road				Pikesvi	lle		100	Baltimore Co	
	Funeral	┪	Social Security Number     6. S	ex 7. Age	(In yrs. last	birthday)	If Under		f Under 24Hrs.	8. Date of Birth (	MM/DD/YYYY) 9. E	Birthplace (State or
	Director		214-27-8156	M 2 F	17	Yrs	Months	Days	Hours Min.	12 18		Country) MD
		1	Usual Residence of Decedent	Z	1/		J	<u> </u>	1.	112 10		
	áu	ŀ	10a. State 10b. County		10c. City, To	own or Locati	ion					10d. Inside City Limits
	p wor		MD NA		Ba	ltimo	re					1X Yes 2 No
	rylan a-f sl	용	10e. Street and Number				10f. Zip C	ode		10g.	Citizen of What Co	ountry?
	e Ma or 28	Director	5406 Gist Ave				l	212	215	1.22	U.S.	Α.
	death with the Maryland or items 23a or 28a-f show any must be notified at once.		11. Marital Status	12. Was Decedent	Ever in U.S.	13. Wa	s Deceden	of Hispar	nic Origin? ( Spe	ecify Yes or No-	14. Race - Am White, etc	erican Indian, Black,
	ath w items	Funeral	1x Never Married 2 Marrie	Armed Forces?	X No	If Y	es, specify	Cuban, M	lexican, Puerto I	Rican, etc.)		·
	her de	티	3 Widowed 4 Divorce	d If Yes, Give Year	**		Yes 2X				Op comy.	Black
	urs af tural amin	d by	15. Decedent's Education (Specify of	only highest grade com	pleted) 1	6a. Deceder	nt's Usual C	ccupation	(Give kind of w		6b. Kind of Busines	ss/Industry
	72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)				0 140 1 000 10			
	thin thin the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference of the reference	npl	llth grade	na		5	tude				Scho	ol
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	21: be fill ntal F rked ent, t	Be	Glen Jarvis						Shirley	y E. St	ewart er, City or Town, St	rate Zin Code)
	21 lould d Me s ma	To	19a. Informant's Name/Relationship	Type, Print )		19b. Mailin	g Address	(Street a				
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		Anniebell Ste	wart-Auni	005 0	5406 ace of Dispo	Gis			ltimore Date	Md 2 20c. Location - City	1215 or Town, State
	Fe, I an Fiter Fiter free		20a. Method of Disposition  1	Removal from St		ematory or o		e or cerne	iory,	2010		
	Pages ent of		4 Donation 5 Other Specific		Arb	utus	Memo	rial	9/1	/07	Arbutus	. Мд
	Baltimo permit. Page Department of Important: injury or otl		21. Signature of Funeral Service Lice	ensee		22	Name and	Address of	West	4		
	E E E E		Xala IV	arch		1/17	$2 \cap \cap V$	iahad	zh λττο	, Balti	more. M	d 21215 Approximate Interval
1	hysician		e. Pin I. Enter the disease, or cor failure. List only one cause on	oplications that caused each line.	the death.	Do not enter	the mode o	t dying, su	ich as cardiac o	respiratory arres	st, snock, or ricart	Between Onset and Death
	Medical _xaminer	9. 3	Immediate Cause (Final disease	a. Multiple Gunsh								Beaut
	_xammer		or condition resulting in death)	Due to (or as a cons	equence of)	:						
		_	Sequentially list conditions,	Due to (or as a cons	equence of	١٠						
		ine	if any, leading to immediate cause. Enter Underlying Cause	c.	,04401100 01)				a Lew			
		Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of	):						
	executed an and al - transi	<u>=</u>		d								
		edical	UNPENDED	AMENDED								
	760, cate be physic he bur	Ĭĕ	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	me of pregr			2	Ectopic pregna	ancy	23d. Date of del Month	Day Year
	Box 6876( e death certificate the attending phy ed for use as the b	sician/M	past 12 months?	1 Live birth	at time of dea		Fetal death Other (Spe	oifu)	_ Ectopic pregni	ancy		,
	eath c atten for us	Sic	1 Yes 2 No 9 Unkno	wn g Unknown		5 (	other (ope					
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	tal Records, P.O. Box 6876 rian: The law requires that the death certificat certificate has been signed by the attending phyector, page 2 should be detached for use as the	۾	•							1 Yes	2 V No 3	Probably 4 Unknown
	duire quire sen sig	Completed					<u>-</u>		-	24a, Was a autops		re autopsy findings available or to completion of cause of
	aw re nas be 2 sho	=								perfor	med? dea	ith?
	Rec The l							00.51	(Dth (Charl	1 Yes 2	Z NO	Yes 2 No
	Vital Recysician: The his certificate director, page	Be	25. Was case referred to medical	Hospital					of Death (Check		Residence 6	Other: Scene
	of Vital Records, ag Physician: The law requir ther this certificate has been some a director, page 2 should!	ا ا	1 ✓ Yes 2 No		tient 2	ER/Outpatie			y at Work?		now injury occurred	
	1 of Ving Ph	=	27. Manner of Death	28a. Date of Ir (Month, Day FOUND:	njury r,Year)	28b. Time of FOUND:	or injury		es 2 V No	Subject sho		
	ion tend leath.	j.	1 Natural 5 Pendin 2 Accident Investig	Aug 27, 200	)7	0150 hrs				29f Location /9	Street and Number	or Rural Route Number, City
3	Division tal or Attendi rs after death.	1	3 Suicide 6 Could			ome, farm, st	reet, factor	y, office bu	Jilding, etc.	an Taum C	tota)	oad, Pikesville, MD
2)	Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certif commenter iffled in by the funeral director.	Certification	4 4 Homicide determ	(-)								
	24 hc			sician: To the best of per:Or the basis of ex	my knowled	ge, death oc	curred at th	e time, dat v opinion	te and place, ar death occurred	nd due to the caus I at the time, date	e(s) and manner as and place, and due	e to the cause(s)
_	To the vithin 2 To the complete	Medical	one) 2 Medical Exam	and manner state	d.			c. License				(Month, Day, Year)
		Ž	29b. Signature and title of certifier	11			25	O.C.N			August 28, 2	
		1	. / // /	1 Knows				U.U.N	VI		/	
	BY	HAI	30. Name and address per an	con le ed cause o	f death (Item	n 23a)	144.5	Ct	Daltimass	MD 21201		
,	2			Deputy Chief Me					, Baltimore,	IVID Z IZU I		
		Stat		2007 32. <b>Re</b> gis	trar's Signat	ure	BALLES					
	Regi	SIF	14 % P D H 3	/ 1111/ 1 E.M. A.R.	applicated at	- 600						

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Edmund Lee Shaffe	er 1- For State Registrar	State of Maryla		rtment of <i>tificate of</i>		d Mental i		2 <b>0</b>	07 2831
Physician/ Medical Examiner	1. Decedent's Name (First,					1	2. Date of Deat Month Septembe	Day Year	3. Time of Death 0218 hrs
	4a. Facility Name (if not ins Route 32 & Inters		mber)	4	b. City, Town, or Jessup	Location of Dea	ath	4c. County of De	
Funeral Director	5. Social Security Number 213-98-2092 213-09-2092	6. Sex	7. Age (In yrs. la	st birthday) Yrs	If Under 1 Year Months Days	<del></del>	fin :		Birthplace (State or oreign Country) MARYLAND
any	Usual Residence of Decedence 10a. State 10b. Co	ent	I10c. City.	Town or Locati	on				10d. Inside City Limits
<b>*</b> .	MARYLAND ANN			BURNIE					1 Yes 2 X No
vith the Maryland 23a or 28a-f show a rotified at once. al Director	10e. Street and Number				10f. Zip Code			0g. Citizen of What C	
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0036 within 72 hour giene. her than "natt EMedical Exau ompleted	Elementary/Secondary (	0-12) College (1	-4 or 5+)	MECHAN			e di Vit	AUTOMOTI	VE
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2121 2121 Mental Mental marked c event,	EDMUND RALPH  19a. Informant's Name/Rel		ID	19b. Mailing	Address (Stree		ARIE DAVI	S nber, City or Town, S	State, Zip Code)
<b>5</b> 2425	JANE M. FRAM							MARYLAN	
imore, MD 2 Pages I and 2 shoul ment of Health and In faut: If item 27 is in or other traumatic		mation 3 Removal fr	om State	rematory or otl	ition (Name of cer ner place) MATORY,	SI	Date EPTEMBER 2007	20c. Location - Cit	LLE, MARYLAND
Baltimore, permit. Pages I and Department of Heal Important: If item injury or other tra	4 Donation 5 Ott 21. Signature of Funer So							IOME, P.A. EN BURNIE,	
Physician	23a, Part I. Enter the disea failure. List only one		aused the death.	Do not enter to	ne mode of dying,	such as cardia	c or respiratory arr	est, shock, or heart	MD 21061 Approximate Interval Between Onset and
/Medical xaminer	Immediate Cause (Final di or condition resulting in de	sease a. Coronary a							Death
	Sequentially list conditions	h Atherosclet	consequence of otic Cardiov		ease				
niner .	if any, leading to immediate cause. Enter Underlying C	e Due to (or as a	consequence of	f): -	· .				:
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c 6876 certificat ending phi use as the Cian/M	IF FEMALE: 23b. Was decedent pregnal past 12 months?	nt in the 1 Live b	outcome of pregi irth ant at time of de	2 Fe	tal death 3	Ectopic pre	gnancy	23d. Date of del Month	livery Day <b>Y</b> ear
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	?	Contributing to							Probably 4 🗹 Unknown
Records, The law require: ficate has been sig. page 2 should be Completed							24a. Was autor	psy prior	re autopsy findings available r to completion of cause of
Rec The la ficate h page 2					_		1 🗸 Yes	ormed? deat 2 No 1	Yes 2 No
of Vital Rec g. Physician: The ther this certificate meral director, page n.: To Be Con	25. Was case referred to n examiner?	Hospital:	Inpatient 2	ER/Outpatient		of Death (Che Other:	rsing Home 5	Residence 6 🗸	Other: Scene
두 를 들린 누	27 Manner of Death	28a. Date (Month	of Injury , Day,Year)	28b. Time of		ry at Work?	28d. Describe	how injury occurred	
Division Is after death.  al Director: / led in by the fi	2 Accident	Pending Investigation 28e Place	e of Injury - At he	ome, farm, stre	et, factory, office t	Yes 2 No	28f. Location (	Street and Number of	or Rural Route Number, City
Division o  Bospital or Attending 24 hours after death. Funeral Director: Afterdy filled in by the funeral Certification:	3 Suicide 6 4 Homicide	Could not be determined (Specify)					or Town, S		
Divisior  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	29a Certifier	ing Physician: To the bes it Examiner: On the basis and manner s	of examination a						
F S F 2	29b. Signature and title of	certifier			29c. Licens O.C.			29d. Date signed September 4.	(Month, Day, Year)
T	30. Name and address of g		se of death (Item	23a)	0.0.	IVI. L.		Joptomber 4.	
12	Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
State Registra		Year) 32. 32. 32. 32. 32. 32. 32. 32. 32. 32.	egistrar's Signatu	y. Spe	when				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are 249 per State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** William Ε. Spraker, 11 August 30, 2007 9:48A M /Medical 4a. Facility Name (If not institution, give street and number)
Holy Cross Hospital 4c. County of Death 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Norths | Days | Hours | Min. | OCt. | 22,1965 9. Birthplace (State or Foreign Country) VII ginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1,□XM 2□ F 41 229-80-8164 Yrs Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or iteme 23s or 28s-f show the Medical Examiner must be natified at Havre Montana HillY Yes 2 □ No Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1042 Lincoln Ave 59501 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Anned Forces? 30 8 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retiped) Master Sergeant 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) Cellege (1-4or 5+) United States Air permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked otheny injury or other treumatic event 906s. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William E. Spraker Drucilla Ellen Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Vanessa L. Spraker/ Wife 1042 Lincoln Ave. Hayre, Montana 59501 20b. Place of Disposition (Name of p remaiery premaiery or other place)
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State S2857 8, Roanoake, Virginia 4 □ Donation 5 □ Other (Specify) Home, INC Rd. 21120on, Md 22. Name and Address of Facility Lee Funeral Hom 633 Old Alexandria Ferry Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MOnthS tmmediate Cause (Final disease or condition resulting in death) Metastatic Esophageal Cancer Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physicien: The law requires that the death certificate be executed physicien ar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, tF FEMALE:

Physician/Medical δ Be Completed ည this Medicai Certification; After death. efter death Director: , filled in by within 24 hours of To the Funaral D completely filled in

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

5 Pending

investigation

6 Could not be determined

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal de 2 Fetal death 4☐Pregnant at time of death 5 Other (specify)

28e. Place of trijury - At home, farm, street, factory, office building, etc. (Specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 Ectopic pregnancy

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X ☐No 3 Probably 4 Unknown

24a. Was an 1☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Hospital: Tipatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of Injury 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 ☐ Yes 2 💆 No

27. Manner of Death

K Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

100 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Steven Seth Wilson,

10063508 20/307 MD Walter Reed Army MedicalCenter, Washington,

State Registrar

10

32. Registrar's Signature 31. Date filed (Month Cay 2007

		ľ	State of Maryland / Department of Health and M  1 - State Registrar Amend #1, perMD, g871, 9/5/07 TT Certificate of Death	lental Hygie		28315
	Physicia	3n	1. Decedent's Name (First, Middle, Last) Harriet V. Sterling	2. Date of Death Month	Day, Year	3. Time of Death
	/Medic	al	Harriett Sterling	September		0805AM
1	Examin	er	4a. Facility Name (If not institution, give street and number)  Johns Hopkins havicu Care Center Baltimore M	200 level	bel timos	0 1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth Month, Day, Y	9. Birt	hplace (State or Foreign
	Director		214 30 4508 1 M 20 F 73 Yrs. Months Days Hours Min.	January 2		ry1and
	yland		10a. State 10b. County 10c. City, Town or Location	· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
	e Mar	Director	Maryland Baltimore Dundalk			1 ☐ Yes 2 🕱 No
	with the a or 2	Dire	106. Street and Number 1735 Brookview Road 21222	109	U.S.A.	ountry?
	death ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	
36	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other then "natural; or Itams 23a or 28a-f ehow event, it e Medical Exemitiet must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	Hican, etc.)	Black, Whit	
21215-0036	2 hour	ted b	15. Decedent's Education 16a. Decedent's Usual Occupation	16	b. Kind of Business	Industry
215	ithin 7: e. en. "n.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of working life. DO NOT use retired)			
121	e filed wi al Hygien other th		12th 17. Father's Name (First, Middle, Last) 18. Mother's Name		ood Servi	.ce
Maryland	id be f ental h ked of	To Be	II D	ret Beatt		
ary	2 should be f and Mental I ie marked of raumatic eve	-	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or Rura</i> )	al Route Number, C	City or Town, State, 2	
	and 2 lealth m 27 i				n, Marylar	
Jore	ages 1 nt of H : If ita		1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)		c. Location - City or Llen Burni	e, Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 ie marked any injury or other traumatic es once.		21. Signature 1 Funeral Service Licensee 22. Name and Address of Facility Gol			
ä	Depa Impo any i		4001 Ritchie Highwa	y Baltin	nore, Mary	land 21225
П			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	or respiratory arrest	,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. left middle curebral artery Atrole			Onsor and beam
	Examiner		Due to (or as a consequence of):			
	T =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
12	ecuter and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last			
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	dicai E	· coronary artery disease			
9	tificate ng phy as the	Medic				
Вох	eath certifii attending p	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of del	ivery Day Year
0		Physician/Me	1 ☐ Yes 2 <b>2</b> No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			
ਰ_		by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
ords	v requires been sign should be	ted t		1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Munknown
Records	aw as b	Completed		24a. Was an autopsy performe	prior to	topsy findings available completion of cause of
Vital	Th este pag	e Col	25. Was case referred to medical 26. Place of Death	1□ Yes 2 E		2 No
<u> </u>		To Be	examiner? Hospital: Other		ce 6 □Other (Spe	cify)
n of			1 Matural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how	injury occurred	
Division	Attanding ir death. ector: Aftei by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be 3 Suicide 6 Could not be	28f Location (Street	et and Number or Ri	ıral Boute Number
Di≤	al or A safter i Direc d in by	Certification;	4 Homicide determined building, etc. (Specify)	City or Town, S		irai nodie Ndimber,
	To the Hospital or At within 24 hours after or To tha Funaral Direct completely filled in by	edicai (	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a companient of the companient of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
	To the within To the comp	Me	29b. Signature and title of certifier 29c. License number	29d	. Date signed (Mont	h, Day, Year)
•			Since a. fordis no D35763	1	iptember	1,001
	4		(Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.  29b. Signature and title of certifier  29c. License number   Himore 1	Nd 21229	4	
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	1	/	
	Registr	ar	SEP 0 5 2007 Marin 20 19			

Share of Maryland Persepart 8871 of Hart Vand Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER Physician FRANCES BERMAN **SULSKY** 2007 2:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4001 OLD COURT ROAD, #511 BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 1859 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛣 F 218-32-<del>1839</del> 97 07/16/1910 NY Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 3a or 28a-f show t be notified at 10a. State 10b, County 1 ☐ Yes 2 🛣 No Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 4001 OLD COURT ROAD, #511 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: items ; Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 , or WHITE 1 ☐ Yes 2 💢 No þ 3 Midowed 4 □ Divorced "natural", Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWNER BOUTIOUE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NATHAN HOROWITZ GUSSIE BERGER ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RIKKI SOLOMON / DAUGHTER 7914 IVY LANE, BALTIMORE, MD 21208 20b. Place of Disposition (Name of general processing Charles and Cong. ALIZ CHAIM CONG. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/03/2007 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Aspiratos preumorio 2 days /Medical Due to (or as a consequence of): Examiner Small boul obstruction 3 weeks Sequentially list conditions, if any leaf of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2xx No 3 ☐ Probably 4 ☐ Unknown Dehydration Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 1☐ Yes 2☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 920604 Kichendo Berg, 40 September 1, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard A. Berg. 40; Svite 450, 10755 Fells Rd., Lutherville, 401 21093 31. Date filed (Month, Day, Year) 32. Fisicar's Signature State

DHMH 17 Rev 1/2001

Registrar

SEP 0 5 2007

	Ł		1 - State Registrar	Ce	rtificate of Death	Reg. I	
	Physici /Medio		1. Decedent's Name (First, Middle, Las				Oay Year 11:30 P M
	Examir			to SPITAL	4b. City, Town, or Location of Death		ACCOUNTY OF DEATH  RALTIMORS
ň	Funeral Director		5. Social Security Number 6. Social Security Number 1  215-54-2891 1  Usual Residence of Decedent	ex 7. Age (In yrs. last birthday, 90 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea 03/05/19)	9. Birthplace (State or Foreign Country) MD
	e Maryland ta-f show	ctor	10a. State 10b. County  MD BALTI	MORE BALTII			10d. Inside City Limits 1  ☐ Yes 2 🛣 No
	h with the 23a or 28 st be no	al Dire	10e. Street and Number  1 POMONA EAST, #	406	10f. Zip Code 21208	10g. (	Citizen of What Country?
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1   Yes 2 (1) No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 1 No Specify:		14. Race - American Indian, Black, White, etc.  Specify: WHITE
21215-0036	within 72 h iene. • than "natu the Medica	omplete	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed)   (Give	ident's Usual Occupation Is kind of work done during most of wor DO NOT use retired) TEACHER		Kind of Business/Industry  EDUCATION
Maryland 2	uld be filed Aental Hyg rked other tic event, i	8	17. Father's Name (First, Middle, Last)	SEI	_KO ROSE	ne (First, Middle, Maid	en Surname) LEVIN
	and 2 sho salth and P 1 27 is ma er trauma	ľ	19a. Informant's Name/Relationship (7	··	ing Address (Street and Number or Ru D STONE CLIFF DRIV		
Baltimore,	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition  1		TN - CHTZIIK		Location - City or Town, State
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen	7	Name and Address of Facility	OL LEVINSON	N & BROS., INC. KESVILLE, MD 21208
	Physician /Medical		23a. Part1. Enter the disease, or come shock, or heart failure. List only of the class of the classes of condition resulting in death)	olications that caused the death. Do not enone cause on each line.  a	ter the mode of dying, such as cardian		Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. URINARY TRACT Due to (or as a consequence of):	INFECTION		
68760,	tificate be executed ig physician and as the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C			
P.O. Box 68	The law requires that the death certificate ate has been signed by the attending physionage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown		⊒Ectopic pregnancy ⊒ Other (specify)		23d. Date of delivery Month Day Year
	quires that in signed by uld be deta	þ	Part II. Other significant conditions of	ontributing to death but not resulting in the u	ınderlying cause given in Part I.		o use contribute to the cause of death? 2□ No 3□ Probably 4 ➡onknown
Division or Vital Records,		Completed	GASTROINTE	STINAL BUSED.		24a. Was an autopsy performed 1∐ Yes 2 ☑	
Vita	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Mo	Hospital: 1 □ Impatient 2 □ ER/Outpatie	Other:	ath (Check only one)  Home 5  Residence	6 DOther (Specify)
ion or	ing After une	ation: To	27. Manner of Death  1 Matural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how in	
Divis	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	te Hospi 24 hour te Funer bletely fill	Medical	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best of my knowledge, dea niner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occurred.	e, and due to the cause urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	Within Voing	Me	29b. Signature and title of certifier	- M.O	29c. License number		Date signed (Month, Day, Year)  655 31 2007
4	, 7		RAVITST. KHUN			MOAUSTO	NN MO 21133
	Sta Registi	rar	SEP 0 5	2007 Asstrar's Signature	bouli		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 27 20/200 AM **Physician** Wogan Starliper, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore WASHINGTON Medical Center Anne. Glen BURNIE ARUNCE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | August 25, 1943 5. Social Security Number 9. Birthplace (State or Foreign Country) Washington, DC 7. Age (In yrs. last birthday) 6. Sex Funeral 1₩ M 2□ F 214-42-5034 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Calvert. Maryland Owings 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code P.O. Box 73 20736 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Communications Technician Metro Media Television 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( 12 should be fi h and Mental H 7 is marked ot John Wogan Starliper, Sr. Ethel Annette Allison ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trau once. Patricia Starliper (Wife) P.O. Box 73 OWINGS, Maryland 20736 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1)(X) Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran Cem Crownsville 8/31/07 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Licensee 22. Name and Address of Facility Fleck Funeral Home UVY M0123 7601 Sandy Spring Road Laurel, Maryland 20707 23a. Part1. Enter the disclase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) colors orders **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No page 2 s autopsy performed? this certificate 1∐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 (Month, Day Year) 5 Pending investigation s after dec. 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and til 957590 8.27.2007. mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) かなプロトンテント)

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day, Year)

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			1 - Stata Registrar		Ce	rtificate c	f Death		Reg. No.	
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last,  OMA  4a. Facility Name (If not institution, give	street and number)	[h	MPS 4b. City, Town	on to cation of Dea		Day Year 3 200 7 4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Security Number 215-40-4381	Chesapea 7. Age (In yrs. It		If Under 1 Ye Months Day		8. Date of Bir	10 Anne 11 Anne 12 Anne 14 1940	thplace (State or Foreign ountry)
	e Maryland se-f show	ctor	10a. State 10b. County Flaryland Anne Aru		, Town or Lo	ocation	Annapolis			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3a or 21	al Dire	10e. Street and Number 1582 Lodge Pole (	Court		10f. Zip Cod	° 21409		10g. Citizen of What C	ountry?
920	be filed within 72 hours after death with the Maryland nial Hygiene. ed other then "natural", or items 23e or 28e-f show event, I're Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Marned  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	ĺ	Was Decedent of Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puel No <i>Specify:</i>	Specify Yes or No to Rican, etc.)	0 4	
21215-0036	d within 72 ho giene. In then "natu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation e completed) College (1-4or 5+)	(Give life.	dent's Usual Oc kind of work do DO NOT use rel	ne during most of wo ired)	irking	Board of Anne Aru	Education
Maryland	should be filed of Mental Hygie marked other imatic event. If	To Be C	17. Father's Name (First, Middle, Last) Orville Thom	npson			18. Mother's Na Marie		, Maiden Sumame) enstein	
	nd 2 shoulth and 27 is m		19a. Informant's Name/Relationship (Ty Andrew Thompson	рө, Print) (brother)			reet, Pas		per, City or Town, State, D 21122	Zip Code)
Baltimore,	Pages 1 arent of Hearnt: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	iemovai nom State	_	sition (Name of matory or other p	1.260	Date t 04	20c. Location - City of Baltimore	
Balti	permit. Pages 1 Department of h Important: If ite any injury or ot once.		21. Signatura o Funera Service Licens	21	22	2. Name and Ad 3111 MO	dress of Facility untain Ro	Stallin ad, Pasa	gs Funeral dena, MD 21	Home, P.A.
li i	Physician /Medical Examiner		23a. Parl . Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that daused the death of cause on each line.  Due to (or as a consequence)	STA		tying, such as cardia			Approximate Interval Between Onset and Death
٨٥, رو	ate be executed sysician and he burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	Ectopic pregna Other (specify,			23d. Date of de Month	livery Day Year
Records, P.	w requires that been signed to should be deta	þ	Part II. Other significant conditions con	ntributing to death but not resu TRUCTIVE LUV	_	nderlying cause	•	12		o the cause of death? robably 4 □Unknown
		Completed							psy prior to death?	utopsy findings available completion of cause of
Vital	sicien certifi irector	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatier	nt 3 DOA		ath Check only	one) dence 6 Other (Spe	
ion of	Hospitel or Attending Physicien: 44 hours after death Funeral Director: After this certificately filled in by the funeral director,	atlon: To	27. Mann of Death  1 atural 5 Pending 2 Accident investigation		28b. Time o Injury	f 28c. Ir	njury at Vork?		how injury occurred	(City)
Division	s after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, str	reet, factory, office	CO CO	28f. Location ( City or To	(Street and Number or R wn, State)	ural Route Number,
	To the Hospitel or Attu within 24 hours after de To the Funerel Directo completely filled in by th	Medical (	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my knowner: On the basis of examination and manner stated.	vledge, deat on and/or in	h occurred at the vestigation, in m	time, date and plac y opinion, death occ	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the I within 2. To the Complet	Ž	29b. Signature and title of certifier	A Anhon	an M	$\bigcap$	16360		Aug ST 2	
	2		30. Name and address of person who co	empleted cause of death (Item	23a) (Type,	Print)	CHWAY K	Luces	Julie MD	21/08
	Sta Registr		31. Date filed (Month, Day, Year)  CFD 0 5 201	32 Registrar's Signat	ure A	342				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1-** For State Registrar Amend 23a, perMD, g871, 9/5/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Hazel Wilson September 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Samare Itimono 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🖫 F 218-80-4344 82 Director 08,1925 North Carolina Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified. Maryland Middle River 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31 Compression Court 21220 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No. Specify 2 Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Welsey Fortner Lela Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Talmage Wilson (Husband) 31 Compression Court, Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 09/07/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediae Cause (Final diseas, or condition resulting in death) Physician Pheumonia (Aspiration) 1 day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-transi Due to (or as a consequence of): Box 68760, attending physician for use as the burial pe Physician/Medical IE EEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.O. 1 ☐ Yes 2 ☐ No. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ş 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has le 2 autopsy page ; perform certificate 1∐ Yes Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗖 Inpatient 2 ER/Outpatient 3 DOA this 2 funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 Natural (Month, Day Year) 5 Pending investigation within 24 hours after deau..

To the Funeral Director: / 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital TSC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Dav. Year) 20058371 Their mia 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thein

State Registrar

Franklin

32 Registrar's Signature

9000

31. Date filed (Month, Day, Year)

07-06797 Garv Watts Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ary Watts	State of Maryland Departy 1-For State Amend #18 Per FH G871 Certifi	ந <b>e</b> nt of Health and Mental F icate of Death	ygiene 2007 2832
Physician/ edical Examiner	Decedent's Name (First, Middle,Last)	WATTS	2. Date of Death Month Day September 1, 2007  3. Time of Death 2237 hrs
	4a. Facility Name (if not institution, give street and number) University of Maryland	4b. City, Town, or Location of Deat Baltimore	4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last to 20 - 11 - 2574 1X M 2 F 21  Usual Residence of Decedent	oirthday) If Under 1 Year If Under 24Hr Months Days Hours Min	1
Maryland 28a-f show any 1 at once.	10a. State 10b. County 10c. City, Too MARYLAND N/A	An or Location  BALTII	10RE CITY 10d. Inside City Limits 1 XYes 2 No
after death with the Maryland and any or items 23a or 28a-f she for must be notified at once oy Funeral Director	10e. Street and Number  3318 ST. AMBROSE  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	10f. Zip Code  2 12 13  13. Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puerl	
99	3 Widowed 4 Divorced If Yes, Give Year or Dates	1 Yes 2 No specify:  a. Decedent's Usual Occupation (Give kind of	Specify: BLACK work done 16b. Kind of Business/Industry
vithin 72 ene. er than Medical	Elementary/Secondary (0-12)  College (1-4 or 5+)  17. Father's Name (First, Middle, Last)	during most of working life. DO NOT use re	PRIVATE ComPANIES e (First, Middle, Maiden Surname)
121 Id be fil tental Is narked event,	GARY WATTS	SR. JA	Rural Route Number, City or Town, State, Zip Code)
nore, MD 2 ages 1 and 2 shoul nt of Health and In: If Itiem 27 is in other traumatic		5340 CARRIAGE  e of Disposition (Name of cemetery, natory or other place)	CT. BALTIMORE MD. 21229  Date 20c. Location - City or Town, State
Baltimore permit. Pages 1 s Department of He Important: If it	21. Signature of Funeral Service Licensee	22 Name and Address of Failty	-08-01/LANGDOWNE, MD. GROWN JRUNERAL HOME NAVE SOALTO MD 21217
Physician 'Medical xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	not enter the mode of dying, such as cardiac	of respiratory air st, shock, or heart Approximate Interval Between Onset and Death
iner	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
ecuted and transit	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.		
e be ex ysician burial	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnant	CV	23d. Date of delivery
D. Box 6876( t the death certificate by the attending physiched for use as the b Physician/Me	1   FEMALE:   23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnant   1   Live birth   4   Pregnant at time of death   9   Unknown	2 Fetal death 3 Ectopic pregr	
P.O. es that the igned by the detach	Part II. Other significant conditions contributing to death but not resul	ting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ✓ No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records, P.O. at or Attending Physician: The law requires that the stafter death.  The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacher iffication: To Be Completed by Pertification: To Be Completed by P			24a. Was an autopsy findings available prior to completion of cause of death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
ital I sician: s certifi irector,	25. Was case referred to medical examiner?  1	26.Place of Death (Check /Outpatient 3 DOA Other Nursi	only one)  ng Home 5 Residence 6 Other:
n of Vital   Iding Physician: h. : After this certif s funeral director, ion: To Be (	27. Manner of Death 28a. Date of Injury 28	b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred Subject shot
Division o spital or Attending hours after death. neral Director: Aft filled in by the fune Certification:	2 Accident Investigation	, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 1300 Block of Rosedale Street, Baltimore, MD
Division To the Hospital or Attendi within 24 hours after death. To the Fumeral Director: a completely filled in by the filled and the filled in by the filled and Certification	29a. Certifier 1 Certifying Physician: To the best of my knowledge, (Check only one) 2 Medical Examiner: On the basis of examination and/c and manner stated.		
	29b. Signature and title of certifier  Mhore Brasil M	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) September 2, 2007
3	Name and address of person who completed cause of death (Item 23a Melissa Brassell, MD Assistant Medical Examiner	a) 111 Penn Street, Baltimore, MD	21201
State	31. Date filed (Moth), Day, Yart 7007 32 Registrar's Signature	Brast i	

State of Maryland / Department of Health and Mental Hygiene 2 1 1 7 28322 Certificate of Death 9/18/07 TT Amend 4b-c, perMD, g871, 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month 8 -**Physician** ONALd /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Baltimore Baltimore If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey,
06 07 If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Days Months M 2□ F Yrs. 73 Director 220-30-3327 Usuet Residence of Decedent the Marylend 10b. County 10d. Inside City Limits 10a. Stete 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified a 1 XYes 2 No Baltimore Directo NA 28a-f MD 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Blvd Apt 202

12. Was Decedent Ever in U,S. Armed Forces?

1 ⊠Yes 2 □ No II Yes, Give by Funeral U.S.A.

14. Race - American Indian, 21236 9506 Perry Hall Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Earnings Certification Social Security Adm. 12th grade 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Edith Mae Clayton Wratchford Charles Gordon 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 21236 19a. Informant's Name/Retationship (Type, Print) 9506 Perry Hall Blvd Apt 202, Baltimore, Md Mignon Wratchford-Wife 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/31/07 Loudon Park Baltimore, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner or Attending Physician: The law raquires that the death certificate be executed Sequentially tist conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Physician/Medical Due to (or as a consequence of) 23b. Did tobecco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2000 †□ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Sursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Tes After this 28a. Date of Injury (Month, Dey Year) filled in by the funeral 28d. Describe how injury occurred 28b. Time of 27. Menner of Deeth 28c. Injury et Work? 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely fi 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and tipe of certifier 29d. Date signed (Month, Day, Year) Blud, Baltimore no 2/239 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 560 31. Dete filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene? 17 28323 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:00 PM ngate 30 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If pet institution, give street and number) Examiner Charlotte Hall If Under 1 Year | If Under 24 Hrs. Veteran's MI Home harlotte Hal 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**∑**M 2□F Months Yrs. Director MARYLAND 87 212-10-7889 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Itema 23a or 28e-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Marylannent of Health and Mental Hygiene.
ant: If Item 27 is marked other then "natural; or Itema 23a or 28e-f ehov ury or other traumatic event, the Madical Examiner must be notified at BALTIMORE 1X Yes 2 No MARYLAND BALTIMORE CITY Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES CHARLES STREET 21230 1818 S. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 Q 11. Marital Status 1943-1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No WHITE 1945 δ Specify. 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER CONSTRUCTION 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GRACE A. HEPP WILLIAM A. WINGATE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIRGINIA CAVENDER / DAUGHTER 23 OUEEN ANNE RD. GLEN BURNIE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) SEPT . Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Department o Important: If any injury or once. CEDAR HILL CEMETERY 2007 BROOKLYN PARK, MD 21. Signature Funeral Service Licensee RKLEY—RUDDICK I CRAIN HWY. S.E. GLEN BURNIE, MD 21060 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician END S7999 DEMENT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 Probably 4 Unknown 1 Tyes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: ၉ 1 Tes 2 No 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitel 29a, Certifier 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D00567 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAZNIN ESPHAN HALL ROAD, 31. Date filed (Month, Day, Year) 2007 SEP 05 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2007 **Physician** Noshiw August Stanton ヒんつ /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Balti more City HOSpita Harbor N/A 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**№** M 2□ F 56 Nov. 217 62 9592 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 √ Yes 2 No N/A Baltimore Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examiner must be r U.S.A. 2810 Booker T Drive 21225 Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) **Hospital** Hospital Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Stanton Wilson Ann Spruill ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21225 Ann Stephens / Mother 2810 Booker T Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or conce. 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 8/31/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bavview Crematory 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 <u>Ritchie Highway</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Myocardial Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): with Respiratory Failure Examiner So use fishly stroy differs if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performe 2 NO 2 No 1 TYes 25. Was case referred to medical examiner? 1 ☐ res 2 ☐ No 26. Place of Death (Check only one) funeral director, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / / filled in by the f 2 Accident 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

within 24 hours after do

To the Funeral Direct
completely filled in by

Registrar DHMH 17 Rev 1/2001

State

**ORIGINAL** 

Baltmore

29c. License number

29d. Date signed (Month, Day, Year)

2007

and manner stated.

S. Hanover

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 200 1. Decedent's Name (First, Middle, Last) 2. Date of Death Wajciechowski Year Physician Bobby August 1820 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIL Baltimore T. Age (In yrs. last birthday) Hopkins Johns If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O2/16/1945 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 😾 F 216-42-5785 Director MD Usual Residence of Decedent t be notified at 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD Baltimore Arbutus 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 1915 Lincoln Ave. 21227 USA 7 Is marked other than "natural", or items 23s traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 27 No Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 Elementary/Secondary (0-12) College (1-4or 5+) Deli Manager Food Service 10 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 Is marked other I any injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles LeBon Barley Stracner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Wojciechowski / Husband 1915 Lincoln Ave., Arbutus, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ▼Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Memorial Park | 08/30/2007 Elkridge, MD 22. Name and Address of Facility
Cary L. Kaufman Funeral Home at MMP,
7250 Washington Blvd., Elkridge, MD 21. Signature of Funeral Service Licensee 21075 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Interstial **Physician** year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and later and Due to (or as a consequence of): Examiner certificate be executed burial-tran Due to (or as a consequence of) physician Physician/Medical the' IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an page 2 autopsy 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 mpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes ၉ this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After: Certification: Injury Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division or Vital Records,



State Registrar 31. Date filed (Month, Day, Year) SEP 05 2007

29b. Signature and title of certifier



Medical Doctor

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 N. Wolfe Street Baltimore Haryland

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

			For State Registrar		State of Ma	arylan		artment of <i>rtificate o</i>		and Menta		iene _{eg. N} 201	07	28326
5F.	Physici /Medi		1. Decedent's Name (	First, Middle, L GILBER		YANC	OVICH			2. Dat Mo Augu		Day	Year 007	3. Time of Death  1:02 A
	Examir Funeral Director			k Memor	ial Hospita Sex 7. Ag		last birthday, Yrs.	4b. City, Town, Freder If Under 1 Yea Months Day	ick ar   If Under 2	24 Hrs. 8. Dat Min. (Mo	e of Birth onth, Day,		deri	
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	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notifiled at	Funeral Director	8505 Spri 11. Marital Status		12. Was Decedent Armed Forces?		S. 13.	Was Decedent of If Yes, specify Co		gin? (Specify Ye n, Puerto Rican,	es or No- etc.)	14. Rac		can Indian,
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Maryland	and 2 sho ealth and I n 27 is ma er trauma		19a. Informant's Nam					ing Address <i>(Stre</i> <b>Young Av</b>					State, Zi	p Code)
Baltimore,	of Heritan		20a. Method of Dispose 1 ☐ Burial 2 🛣 4 ☐ Donation 5	Cremation 3	□Removal from State	0	emetery, cre	osition (Name of matory or other p ke Crema		Date Aug 2007	31	20c. Location		own, State Maryland
Balti	permit. Pag Department Important: I any injury o		21. Signature of Fund	erat Service Lic	ensee M	0038	2 2	2. Name and Add Rapp Fund 933 Gist	eral &	Crematio	n Ser	vices Maryl	and 2	20910-
68760, <	eath certificate be executed  Attending physician and attending physician and for use as the burial-transit	edical Examiner	23a. Part1. Enter the shock, or heart Immediate Cause (Fi disease or condition resulting in death)  Sequentially list and if any, leading to immediate. Enter Unders Cause (Disease or in that initiated events resulting in death) La	nal	a.  Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a	a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence	myof: uence of): n+es uence of):	>athy	blee		ratory arre	est,		Approximate Interval Between Onset and Death
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or Vital Records,	The law requir ate has been si bage 2 should I	Completed		Space	qe Ren	011	2)	spase			1  Ye a. Was a autops perforr	n 24b.	Were aut	opsy findings available ompletion of cause of
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Division	Atten r death ector: by the	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigati 6  Could not determine	be I ago Place of ini			M   1	□Yes 2⊡l e	28f. Loc	cation (St by or Town	treet and Numi n, State)	ber or Rui	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Din completely filled in I	Medical C			Physician: To the best aminer: On the basis of and manner st	f examina								
	To th within To th	Me	29b. Signature and ti	tle of certifier					ense number			9d. Date signe		-
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	67	ot c	30. Name and address  Hemen  31. Date filed (Month)	Shah	o completed cause of d	Thor	Mas	Johnsa	n br	Fr	ede	vice	MS	21702
	Regist	ate rar		D O E 2			-	100						

DHMH 17 Rev 1/2001

			For State Registrar		State	of Mai	ryland				lealth ai Death	nd Me	ental Hy	giene Reg. No.		7	283	327
7	Physici /Medi		1. Decedent's Name Meredit										2. Date of De Month 1gust	Day	2007	ar	3. Time of <b>6:21</b>	Death A M
	Examir		4a. Facility Name (// Holy Cro			l number)					Location of	Death			County of D			
	Funeral Director		5. Social Security N 409-59-11	iumber 6	. Sex 1			ast birthday) 48 Yrs.		er 1 Year		Min.	B. Date of Bir (Month, Da	th ly, Year)	9.1	Birthpla Country	,	r Foreign
ight.	D		Usual Residence of 10a. State					Town or Lo	cation		LL	ĪN	ov. 12	, 19	30   PE	anam	I. Inside Ci	h/ Limite
	Maryla t-f sho fied at	tor	Maryland	Montgon	nery			ville								100	1x Yes	•
	or 288	Director	10e. Street and Nur	nber					10f. Zi	p Code				10g. Citi:	zen of What	Country	^{/?} Ameı	cica
	eath w is 23a nust l		14004 Co	ve Lane		Decedent Ev	or in II S	10		851	iononio Oriei	in2 (Cnoo	ih. Von av Nia		ed Sta			
036	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral		ied 2 <mark>k⊋</mark> Married 4 □ Divorced	Armed	d Forces? es 2 <del>∏</del> No		1			Specify: P		ify Yes or No ican, etc.) anian		Black, W		0.	
Maryland 21215-0036	72 ho "natur	Completed	(Spec	15. Decedent's cify only highest	Education grade complete	ed)	Į.	16a. Deced	kind of w	ork done	during most o	of working	7		nd of Busine			·/Dent
121	l within jene. r than the Me	ошр	Elementary/Seco	ndary (0-12)	-	ge (1-4or 5+) <b>5+</b>	)			retired t / P	" rogram	n Man	ager H	į.	h& Hur			_
nd	al Hyg	Be C	17. Father's Name		ıst)				<i>y</i>				First, Middle	Maiden	Surname)			
ry Ia	hould be filed and Mental Hyg marked other matic event, t	ဥ	Granville 19a. Informant's Na			bert		10b Mailie	a Addusa	o (Cáro ot			11a Br		T 01-1	. 7: 0		
Ma	alth an 27 is r		Laurence			/Husba	and									a, zip C	oae)	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev		20a. Method of Disp	oosition Cremation 3	☐Removal fro	om State	20b. Pla	ace of Dispo metery, cred Juan I	sition (Na	me of other plac	e) Au	Da Da	,2007	20c. Lo	cation - City	or Tow	n, State	
<u>=</u>	it. Pag irtment irtant: njury			5 ☐ Other (Spe	cify)		Cem	enteri	Lo Co	ncep	cion				a Cit			<b>a</b>
g	Depa impo any l	k s	D Will	Werel Service Lik	12 B	- CAM							W Was					
a s		<u>k</u>	23a. Part1. Enter the shock, or hea		omplications th	at caused the	ne death.	Do not ent	er the mo	de of dyin	g, such as ca	ardiac or	respiratory a	rrest,		li li	pproximatenterval Betwood	ween
	Physician /Medical		Immediate Cause ( disease or condition resulting in death)	Final a		tasta to (or as a			t Car	cer						1	maet and L	
	Examiner	<u>.</u>	Sequentially list con	nditions,	b. Due	to (or as a	CORSONIA	ance of):										
	outed d ansit	Examiner	Sequentially list confidence if any, leading to improve the Cause (Disease or that initiated events	llying injury	200	10 (01 43 4	oonseque	siles oi).										
ρΩ,	icate be executed physiclan and s the burial-transit		resulting in death) L	.ast	Due	to (or as a	conseque	ence of):										
08/PN	ificate g physi as the t	edical			d													
O. BOX	the death certificate be executed y the attending physician and ched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☑ 9 ☐ Unknown	months?	1□Liv 4□Pr	outcome pf ve birth 2 regnant at ti nknown	☐ Fetal o	death 3	Ectopic p Other (s	oregnancy pecify)				2	3d. Date of Month			ear/
S,		by Ph	Part II. Other signif	icant condition	s contributing to	o death but	not result	ting in the ur	nderlying	cause give	en in Part I.		23e. Did t	obacco u	se contribute	to the	cause of d	eath?
ecords	requires that een signed b nould be deta										<u>-</u>	_	1 🗆	Yes 2	] No 3 □	Probab	oly 4X∏L	Jnknown
<u>r</u>	The lar ate has page 2	Completed										_	24a. Was auto perfo 1∐ Yes		24b. Were prior death	to comp i?	y findings a detion of ca	available ause of
VII	Physician: this certific	o Be	25. Was case referrexaminer?		Hospital: 4.	<b>☆</b> Inpatient	205	D/Outnotion	+ 3□ D	Othe			Check onl					
Vision or	To the Hospital or Attending Physician: within 24 hours after deal and the Funeral Infector. After this certific completely filled in by the funeral director,	$\vdash$	27. Manner of Death  1   Natural  2   Accident		28a. Da	ate of Injury Month, Day	2	28b. Time of Injury		28c. Injun Worl		28	5 ☐ Resi			pecity)		
LINIS	ai or Attending I s after death. al Director: After ed n by the funer	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	28e. Pi	ace of injury uilding, etc.	- At hom (Specify)	ne, farm, str	eet, factor	y, office		28	f. Location ( City or To			Rural F	Route Num	ber,
	the Hospital in 24 hours a the Funeral I	edical (	29a. Certifier (Check only one)	1 X Certifying i 2 ☐ Medical Ex	aminer: On th	the best of e basis of e nanner state	xaminatio	ledge, death on and/or in	occurred vestigation	l at the tin	ne, date and pinion, death	place, an	d due to the	cause(s) date and	and manner place, and	as stat	ed. he cause(s	)
)	To the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complet	M	29b. Signature and	title of certifier	la	Tika	ng	MA		c. License		-			e signed (Mo			
3	65		30. Name and addre Etonde M							Rd.	Silve	er Sp	ring,	MD 2	0910-	1484		
	Sta Registr		AUG 2 0 2	Day Year)		2. Registrar's												

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2832**8** Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2007 6:45 A August 24 Darwin Earl Brewer, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert 1521 Oak Drive Huntingtown If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**∑**M 2□F July 30, 1948 Wash., D.C. 59 212-54-3584 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 ☑ No Directo MD Calvert Huntingtown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with tent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or Items 23a or 2 ary or other traumatic event, the Medical Examiner must be n 1521 Oak Drive 20639 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced ear or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) budget analyst sanitary water utility 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theophane Esther Miller Darwin Earl Brewer, 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1521 Oak Drive, Huntingtown, MD 20639 Margaret E. Brewer, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Highlands 08-29-2007 | Port Republic, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Prostat rars resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical attending | for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 2 No 1 ☐ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending investigation 1 □ Yes 2 □ No neral Director: 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00059061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 Road, Suite 212, Prince Frederick MD 20678 32 Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Т. Mark Brown August 2007 4:45P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly <u>Prince Georges Hospital</u> Prince Georges If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F Director 578-76-1247 51 Nov.8,1955 Wash.,DC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☑ Yes 2 ☐ No Director Seat Pleasant Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be r 20743 United States 1419 70th Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritai Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔁 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Black þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor <u>VA Linen</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johnson ဥ Earl Brown Juanita 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10100 Gayleswines Court 19a. Informant's Name/Relationship (Type. Print) Earl Brown/brother Bowie, Md. 2

20b. Place of Disposition (Name of cemetery, crematory or other place) 20721 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Riverdale Crematory 9/1/07 Riverdale, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preemonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an Were autopsy findings available prior to completion of cause of certificate has be irector, page 2 s autopsy performe To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 1 Death 2 Accident 28d. Describe how injury occurred 28a Date of Injury 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) chevery MD 20785 1 Hospital DP-82. Registrar's Signature Mahn evvi 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

0 5 2007

# **VOID**

# CERTIFICATE #

*20*07 - 28330

### SEE

CERTIFICATE #

2007 - 13749

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Dav August 2007 Loretta Truitt Braithwaite 4c. County of Death 4b. City, Town, or Location of Death 4a/facility Name (If not institution, give street and number edical alisbury 1comics ent ninsula Teglona If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 X F 53 212-66-0705 Maryland 12-1-1953 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No MD Wicomico Salisbury 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 110 Cloverdale Street 21804 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2√ No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Flight Support Air Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Basil Truitt Lorraine Baylis 19a. Informant's Name/Relationship (Type. Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Cloverdale Street, Salisbury, MD 21804 of Disposition (Name of Date 20c. Location - City or Town, Dennis Braithwaite - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parsons Cemetery 8-18-2007 Salisbury, Maryland 21. Signature V Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Vish rinder for Brither. Minch Due to (or as a consequence of): Myacardel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Ma Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ☐ €R/Outpatient 3 ☐ DOA 1 ☐ Yes 1 | Inpatient 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

death certificate be executed burial-trar Box 68760, attending physician the as nse Por P.O. the Division or Vital Records, has certificate

Examiner Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certifica

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

**Funeral** 

Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "any Injury or other traumatic event: the Mex

Physician

/Medical

Examiner

Maryland 21215-0036

Physician/Medical þ Completed Be 2 completely filled in by the funeral Certification:

within 24 hours a To the Funeral C the 2

29b. Signature and title of certifier anockens m

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

SMISTRY

DMYOUG

03

21804

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CITOREUNA MO 106 MILERO

2007

determined

40250 H

31. Date filed (Month, Day, Year) AUG 1 7

4 | Homicide

29a. Certifier

Medical

State

Registrar

32 Registrar's Signature

H 8 05

			State of Maryland / D	Department of He Certificate of D			-	007	20222
			• Hegistrar	Certificate of D	eaur		h	007	28332
	Physicia	_	1. Decedent's Name (First, Middle, Last)  Delphine C. Black			2. Date of Deat	Day	Year U7	1000 M
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or L	_ocation of Death	3	4c. County		
)	Examin	er	Peninsula Regional Medical Cente	er Sal	isbury		W.	Comi	ed
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bird	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) April 6	Year) 1939	Coun	lace (State or Foreign try) MD
-	PL ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	n or Location				10	0d, Inside City Limits
	show show	'n	MD Wicomico Salisk						1 Yes 2 No
	the M 28a-f notifie	recti	10e. Street and Number	10f. Zip Code		1	0g. Citizen of	What Coun	itry?
	3a or	Funeral Director	558 Gateway Village	21801			USA	Δ	
	death	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - America	
0	or Ite	F	1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🛣 No If Yes, Give	1 ☐ Yes 2 🙀 No	Specify:		Speci	fy: Blac	:k
2-003e	72 hours after death with the Maryland Inatural", or Items 23a or 28a-f show dizal Examiner must be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education 16a.	Decedent's Usual Occupat	tion		16b. Kind of E	Business/Inc	dustry
2	in 72 n "na Medic	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done du life. DO NOT use retired)	uring most of work	ing			
7	d with giene er tha	ĕ	6th	Cook				staur	ant
and	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name		Maiden Surna	me)	
<u>\}</u>	nould I Men narke	은	George Cottman  19a. Informant's Name/Relationship (Type. Print)  19b.	b. Mailing Address (Street at	Elizabet		r. Citv or Towr	n. State. Zip	Code)
<u>a</u>	d2sh thanc 7 is n traun		104. 1110.1114.10	02 Smith St.,					, A
<u>ი</u>	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 20b. Place o	of Disposition (Name of ery, crematory or other place		Date	20c. Location	- City or To	own, State
Ē	Page nent o nt: If		1 X Burial 2   Cremation 3   Removal from State	Acres Mem Pa		/2007	Salisk	oury,	MD
Baltimore,	permit. Pages 1 and Department of Heali Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licensee	22. Name and Address Lewis N. W	Takanan Th	neral H	ome.		
<b>D</b>	9 9 E E 9		Jalana Dalson	1618 West	Rd., Sal	isbury,	MD 218	301	Approximate
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode or dying	y, such as cardiac	or respiratory at	,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence					-	
	Examiner			oi).					
L		Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that biffer a graph.	of):					
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Division or Vital Records,	'sician: The law s certificate has b lirector, page 2 s				26. Place of Dea	1∐ Yes ith <i>Check onl</i> o	2 No	1 ☐ Yes	2 □ No
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סר	Attending Physician: r death. ector: After this certifics by the funeral director, i	Ë	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b.	. Time of 28c. Injury	y at k?	28d. Describe	now injury occ	urred	
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ĬŽ	or Attene after death Director: In by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, f building, etc. (Specify)	rarm, street, factory, office		City or To	vn, State)	nber or nar	ral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page			ge, death occurred at the tir	me, date and place	e, and due to the	cause(s) and	manner as	stated.
	e Hoor 124 h	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.			arred at the time,			
	To the within To the comp	Me	29b. Signature and title of certifier	29c. Licenso			29d. Date sig	,	, Day, Year)
					2107		8-20	0-07	
			30. Name and address of Derson who completed cause of death (Item 23a)	(Type, Print)	Salich	nuna mi	0 218	01	
/g	Ç:	tate	31. Date filed (Morith, Day, Year) 32 Registrar's Signature	Carroll Street	-10C13	Mry III	013	- 1	
	Regis			A. T. T. T. T. T. T. T. T. T. T. T. T. T.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Bounds Scott 19, 2007 0325 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner & NURSING CENTER SALISBURY, MD. 21804 WICOMICO SALISBURY REHAB If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 11/9/1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🕱 F Canada 85 216-12-1241 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or iteme 23s or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 Ves 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA 1513 S. Division St. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married white If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other then any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) 12 Clothing Manufacturing Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maude Craddock Alexander Hume Scott ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Dale Bounds/husband 1513 S. Division St., Salisbury, MD 21804 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition wicomico Memorial Park 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 8/23/07 analure of Euneral Service Licensee ²²Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, ND 21804 arid H. Damprow CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 000 /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached 9 Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed' efter death.

Director: After this certificete I 1 ☐ Yes 2 - NO 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) ဥ 1 🗌 Yes 2 1 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ⊟Najural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 To the Hospital within 24 hours e To the Funeral C completely filled 1 Contitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

WILLIAM ROBINS, M.D.

Day, Year)

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Registrar's Signature

Itimore,

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Box 68760,

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**Division** 

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200 CIVIC AVE., SALISBURY, MD.

21804

		For State Registrar	State o	f Marylaı	nd / Depa <i>Cer</i>	artment o	of Hea <i>of De</i>	ilth and M eath	lental Hy	giene Reg. No. 2	07	283	34
		Decedent's Name (First, Middle, L.							2. Date of De Month			3. Time of	
Physic /Med		Colleen Angela B	runer						August	22, 20	o ^{Year}	3:45	$P^{M}$
Exami		4a. Facility Name (If not institution, g	ive street and nu	n <i>ber)</i>				ation of Death		4c. Count			
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Funeral Director		5. Social Security Number 6. 175–30–1995	Sex 1 ☐ M 2 <b>K</b> F		70 Yrs.			Under 24 Hrs. lours Min.	8. Date of Bir (Month, Da March	13,1937	Coun	lace (State or htry) sylvan:	
pur »		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation					1	0d. Inside Cit	v Limits
/anyle	ō	MD Garrett			ntsvill							1 🗌 Yes	
the A	Director	10e. Street and Number	•	GLa	11024111	10f. Zip Co	ode			10g. Citizen of	What Cour	ntry?	
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Itid X IX I 3-0030  be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23a or 28e-f ahow event, the Modical Examiner must be notified at	Completed	15. Decedent's (Specify only highest of	Education grade completed)		(Give	tent's Usual D kind of work of DO NOT use r	done durin	n ng most of work	ing	16b. Kind of E	Business/Inc	dustry	
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Hygir III		17. Father's Name (First, Middle, La	st)		perr-	-employ		Mother's Nam	e (First, Middle	, Maiden Suma			
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und 2 alth a 27 is		Kimberly K. Glots	felty/Dau	ıghter	16088	Bitti	nger	Rd., G	Frantsvi	lle, MI	215	36	
of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	-	20b.	Place of Dispo	natory or othe	r place)	!	Date	20c. Location	•		
Page nent ant: If		4 Donation 5 Other (Special		Gr	antsvil	le Cem	eter	y Aug.	25, 200	7 Grant	svill	e, MD	
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91		30. Name and address of person wh	no completed cau	se of death (Ite	em 23a) (Type,		OUTUC	11		0	20	2007	
0	1	Dr. Kenneth Bucz	ynski, M	.D., 3	11 N. F	ourth :	St.,	Cakları	d, MD	21550			
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Regis	rar	MAN A	1 0 KUU/	N. A. Sandar	L: 000	A STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STA	9-18						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 15,2007 BERNSCHEIN August JULIA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisburg Wicomico Peninsula Regional Medical Ctr. If Under 1 Year | If Under 24 Hrs. Security Number Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1□ M 2XF 86 218-10-4460 JUNE 5, 1921 Director MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1X Yes 2 No Director DELAWARE SUSSEX SELBYVILLE "natural", or items 23a or 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 19975 31 EAST MILL POND DRIVE USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: WHITE ģ 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the PAYROLL ADMINISTRATOR CITY GOVERNMENT 12 Health and Mental Hygi em 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe EMIL WINICKI AMELIA CILINSKI Pages 1 and 2 should 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
important: If Item 27 is
any injury or other trau 31 EAST MILL POND DRIVE, SELBYVILLE, DE. 19975 JOYCE S. WILKE/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 Other (Specify) DELAWARE VETERANS CEM 8/21/07 MILLSBORO, DELAWARE 21. Sign Ture uneral Service Liotense 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part1. Enter the disease, or complications shock, or heart failure. List only one care caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** 076 disease or condition resulting in death) 000 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examiner certificate be executed ng physician and as the burial-tran Due to (or as a consequence of) Ju (10, Bern Schein Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached 9☐Unknown 9 ☐ Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 → No 3 □ Probably 4 □ Unknown 1 □ Yes cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No 1∐ Yes 2 1 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 H0 1 Inpatient ဥ 2 ER/Outpatient 3 DOA funerai 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical

State

(Check only one)

29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200 egistrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d, Date signed (Month, Day, Year)

Ave. Salisbury, MD 21804

amend line 10e per fd aaco hlth dept 8/30/07 dlw Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-06541 State of Maryland / Department of Health and Mental Hygiene Tyler Lamotte Brown **20**07 28336 Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Month Day August 23, 2007 Physician/ 1630 hrs Medical Examiner Tyler L. Brown 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Severn 1234 Reece Road If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Months Hours comaryland Director 27 1962 Vrs 45 1X M 2 554-17-0562 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 Yes 2 X No Severn 28a-f show Maryland Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1234 Reece Road USA 21144 Rd. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11 Marital Status items a If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? "natural", or item | Examiner must b 1 X Never Married 2 Yes 2 X No Specify: Black If Yes, Give Year Yes 2 X No specify: Divorced 2 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 lant of Health and Mental Hygiene. d other than ", the Medical I NOVA Construction 21215-0036 Construction Worker 0 12th 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Reba Brown If item 27 is marked å Bruce Bailey (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD Md_ Middle River Nocolay Way Eyvette Bailey(Sister) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State 8-29-07 Baltimore, Md. Metro Crematory tant: Donation 5 Other Specify: 010 Whome a Reduse Facility Sons Mortuary, 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 S. Rees Mock83 Part I. After the disasse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death /Medical Acute and organizing pneumonia Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED #23a,27.perME,g871, 9/11/07 Tt ysician a burial -X UNPENDED Hospital or Attending Physician; The law requires that the death certificate be-23d. Date of delivery Box 68760 ttending phys r use as the bu 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown <u>۾</u> 24b. Were autopsy findings available Completed 24a. Was an has been s prior to completion of cause of autopsy death? performed? ✓ Yes 2 1 🗸 Yes No certificate 26 Place of Death (Check only one) 25. Was case referred to medical Be Other₄ Nursing Home 5 Residence 6 Other: Scene examiner? Hospital: 1 DOA ER/Outpatient 3 Inpatient 2 this 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification: Yes 2 No 1 X Natural Director: Pending 24 hours after death. Investigation 2 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be 3 Suicide determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 24, 2007 O.C.M.E. omice 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Patricia Aronica-Pollak MD. 31. Date filed (Month, Day Year) 0 2007 strar's Signature State Registra

ORIGINAL

			State of Maryland / Department of Health and M	Mental Hygier	ne	20227
			1 - State Registrar Certificate of Death	Reg. I	No.2007	28331
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	LAdiliiii	C1	6011 Telegraph Road Elkton		Cecil	
-34	Funerai		5. Social Security Number 6. Set 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 44 2 - 24 - 81 75 1 M a 2 F 79 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	ar) Coun	ace (State or Foreign fry)
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	ryland how		10a. State 10b. County 10c. City, Town or Location		11	Od. Inside City Limits
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9	after or ite		11. Marital Status  Armed Forces?  1 Never Married 2 Married  1 Yes 2 No  If Yes, specify Cuban, Mexican, Puerto  1 Yes, Give  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No	Hican, etc.)	Black, White,	etc.
2-003	be filed within 72 hours after death with the Maryland ntal Hygiene. Be other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by	3 ☐ Wildowed 4 ☐ Divorced   Year or Dates:	16b	. Kind of Business/Ind	lustry
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Ba	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility 5 trano 4 Feel et  635 Church mad		y Funer Jewark,	DE 19702
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	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,	edical	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one)  and manner stated.			
	To the vithin comp	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month,	Day, Year)
)			Physician D0056327		8/16/07	
	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	e am m	41921	
	δ Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	WILL ALL O	112	
H	Registr	ar	AUG 2 0 2007 June & Sparks			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** THEODORE PHILLIP BELT AUG /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Lorien Columbia Nursing & Rehabilitation Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 X M 2 □ F 579-10-9419 85 12-18-1921 Washington, DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 X Yes 2 No Funeral Director Silver Spring Mary land Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number be ns 23a / 2840 Aquarius Avenue 20906 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ₭ Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: White Specify Completed by 3 X Widowed 4 ☐ Divorced WWII 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) strourd by more and Mental Hygiene.

s marked other than "r Office Elementary/Secondary (0-12) College (1-4or 5+) Government Printing Lithographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be fill lealth and Mental H im 27 Is marked oth Be Ethel Louise Kidd Phillip Raymond Belt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health 2840 Aquarius Ave, Silver Spring, Maryland 20906 Ann L. Duewer - Daughter Department of Health Important: If item 27 any Injury or other to once. Pages 1 a 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery | 08-24-2007 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service, Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Hyattsville, MD 20781 Gasch's Funeral Home, P.A. ton sla 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DAYS SFPSIS /Medical Due to (or as a consequence of): **Examiner** moneth CEREBROYASCUL

Physician

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within 24 hours a

Certification:

Medical

certificate be executed

Box 68760.

P.O.

Division or Vital Records,

Physician:

Baltimore, Maryland 21215-0036

Examiner as the burial-trai Physician/Medical nse for signed by the a d be detached f þ Completed page 2 funeral director, Be 2

Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4□Pregnant at time of death 9□Unknown

3 □Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 | Yes 2 | No 3 | Probably 4 Denknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

Due to (or as a consequence of):

Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

26. Place of Death (Check only one) 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

autopsy performed?

24a. Was an

1□ Yes

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier

25. Was case referred to medical

2 10

5 Pending

investigation

6 ☐ Could not be determined

examiner's

1 Tes

27. Manuer of Death

1 ☑ Natural 2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

00053150 AVG192007

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9650 Santopo Rd Sute 110 mp you wnmale Supple 32 Registrar's Signature

29c. License number

Registrar

31. Date filed (Month, Day, Year) AUG 2 2 2007

and manner stated

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07-06405	
Dameon Brown	

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	.o or many taken a	Certifica	ate of	Death			Reg	j. No.	200	7 2833
Physicia	an/	1. Decedent's Name (First, Middle,	•			-		_ N	ate of Death Nonth	Day	Year	3. Time of Death 1536 hrs
ledical Exami	ner	DAMEON ROY BROW				b. City, Town, or	Location of		ugust 18,		ounty of Death	1530 IIIS
		4a. Facility Name (if not institution, Prince George's Hospit	•		*	Cheverly	Location of	Deam			nce George	's
Funeral				(In yrs. last birt	nday)	If Under 1 Yea	r If Under	24Hrs.  8.	Date of Birth	(MM/DD		hplace (State or
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		Usual Residence of Decedent				449			, , , ,			
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tems st be	neral	<ul> <li>11. Marital Status</li> <li>1 X Never Married 2 Marie</li> </ul>	12. Was Decedent I Armed Forces?			Decedent of His es, specify Cubar				14.	. Race - Americ White, etc.	can Indian, Black,
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21215-00 21215-00 buld be filed wit I Mental Hygien i marked other ic event, the Me	o Be	ROY LEE BROWN  19a. Informant's Name/Relationshi	(Type, Print )	198	. Mailing	Address (Stree			BACON Route Numb		or Town, State	. Zip Code)
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Baltimore, MD 21215-00. permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Met		21 Signature of Funeral Service Li		TELES OTTE		ame and Address						
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Hospi 24 hou Funer tely fil		One Continue	sician: To the best of my		ath occur	red at the time, d	late and place				nanner as state	ed.
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical		iner: On the basis of exan and manner stated.									
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J HA		Doma n	winut, mo	D.		0.0	.M.E.			Augus	st 19, 2007	
- WE		30. Name and address of person w	·		444	Dan- Ot-	. D-III:	N/D /	24204			
		Donna M. Vincenti, MD  31. Date filed (Month Day, Year)			111	Penn Street	i, baitimo	ie, MD 2	1201			
S: Regis	tate trar	31. Date filed (Month 2 2 200	7 Brew	S. Op	este	,						
	_			/-								

Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Division or Vital Records, P.O. Box 68760 signed by t After Director: within 24 hours after

To the Funeral Dire

completely filled in b

Baltimore, Maryland 21215-0036

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OXONHILRO. OXON HILL MD. 20745 31. Date filed (Month, Day, Yea

D0637066

AUG 2 1 2007 Registrar

Speck

			State Registrar	tate of Maryla		rtificate of L		R	leg. No <b>2</b> (	107	28341
	Physici	an -	Decedent's Name (First, Middle, Last)					Date of Dea     Month	Day	Year	3. Time of Death
	/Medic		Cheryl Berders					08	18	2007	11 40 PM
	Examin	er	4a. Facility Name (If not institution, give stre			_	Location of Death		4c. Cou	nty of Death	
			University of Maryland M			BACTIMU		0 D-1- (Di-		1 0 5'''	
	Funeral Director		311-10-3413	2 F 7. Age (In y	rs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Dec 27,	1954		lace (State or Foreign htry) hington, DC
	ryland how at		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				1	Od. Inside City Limits
	a-f s	Director	District of Columb	ia	Washing	ton					1 TyYes 2 □ No
	or 28	<u>Sire</u>	10e. Street and Number			10f. Zip Code		1	10g. Citizen	of What Coun	ntry?
	23a ust b		3034 - 24th Street,	NE		20018				d State	
336	be filed within 72 hours after death with the Maryland that Hyglene.  dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	1X Never Married 2 Married	Was Decedent Ever ir Armed Forces? 1		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2☐XNo	spanic Origin? (Spanic Origin? (Spanic Origin), Mexican, Puerto  Specify:	ecify Yes or No- Rican, etc.)	E	Race - Americ Black, White, ecify: B1:	etc.
ş	2 hou	ted	15. Decedent's Educati	on	16a. Dece	dent's Usual Occupa	ation	Í	16b. Kind of	f Business/Inc	dustry
9500-5121	within 7 iene. r than "n the Medi	Completed		College (1-4or 5+)		kind of work done of DO NOT use retired mputer An		ng	Priv	vate	
7. 0	filed Hygi other	ပိ	17. Father's Name (First, Middle, Last)	V			18. Mother's Name	(First, Middle,			<del></del>
<u>a</u>	ld be ental ked (	To Be	Curtis Borders				Matlene	Johnso	n		
Maryland	shoul nd M marl	ř	19a. Informant's Name/Relationship (Type.	Print)	19b. Mailii	ng Address (Street a	and Number or Run	al Route Numbe	r, City or To	vn, State, Ziç	Code)
<u>s</u>	nd 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 state and 2 s		Curlene Wellington	- Sister	4205	Lawrence	St Colm	er Meno	r MD	20722	
ā,	Pages 1 and 2 should be file ent of Health and Mental Hy nt; If item 27 Is marked oth ry or other traumatic event	1	20a. Method of Disposition	200	o. Place of Dispo	osition (Name of matory or other place	DL. COTI			on - City or To	own, State
Baltimore,	Pages nent of I int; If ite		1   Burial 2 □ Cremation 3 □ Rem  □ Donation 5 □ Other (Specify)			em. Cemet		25, 200	7 Su	itland	• MD
Ē	artme	1	21. Conature of Furneral Service Licensee	1		2. Name and Addres					
ñ	permit. Page Department Important; If any injury or once,	d l	Mehney tell	to some	411	001 Benni				-	
			23a. Part1. Enter the disease, or complicat	one that caused the d	eath. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician	or a	shock or heart failure. List only one of immediate Cause (Final	SEP5is						1	Onset and Death
1	/Medical		disease or condition resulting in death)	Due to (or as a cons	seguence of):					-	5 0445
	Examiner			,	. ,						
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	sequence of):						
	outed Id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c								
o`	an ar rial-t	EX	resulting in death) Last	Due to (or as a cons	sequence of):						
08/60	ficate be executed g physician and ss the burial-transit	edical	d								
	± 50 m	Med	IF FEMALE:								JULY 1915
X R R	eath certif attending for use as	an/l	23c. 23c. in the past 12 months?	If yes, outcome pf pre 1☐Live birth 2☐F	etal death 3	⊒Ectopic pregnancy	1		23d.	Date of delive	ery Day Year
-	the at	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	of death 5[	Other (specify)					Day Tour
J.	d by letach	Phy	Part II. Other significant conditions contrib	uting to death but not	resulting in the u	nderlying cause give	en in Part I	23e Did to	hacco use c	ontribute to t	he cause of death?
Š	n requires that the de been signed by the s should be detached	by	Endemetrial can	-	_	naonymg oaabo grv	on mir aren.	1 U Y			oably 4 □Unknown
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Vital Records,	ysician: The law requires that the death cert is certificate has been signed by the attending director, page 2 should be detached for use	Completed								lb. Were auto prior to co death? 1 ☐ Yes	ppsy findings available mpletion of cause of
<u> </u>	ian: ortifica ctor, p	Be C	25. Was case referred to medical examiner?	20 24247			26. Place of Deat		-		
	nysic nis ce direc	To	1 ☐ Yes 2 No Hos	pital: 14 Inpatient 2	P. ☐ ER/Outpatie	nt 3□ DOA Othe	er: 4 Nursing Ho	me 5□Resid	lence 6 🗆	Other (Specia	(y)
n or	ng Pl		27. Manner of Death  1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time o	of 28c. Injury Worl	y at k?	28d. Describe h	ow injury oc	curred	
<u> </u>	tendi eath. or: A	cati	2 Accident investigation				Yes 2 □ No				
DIVISION	I or Attending Physician: after death. I Director: After this certification by the funeral director, I	Certification:	4 Homicide determined	28e. Place of injury - A building, etc. (Sp.	it home, farm, sti ec <i>ify)</i>	reet, factory, office		28f. Location (S City or Tow	treet and Nu n, State)	mber or Rur	al Route Number,
	To the Hospital or Att. within 24 hours after de To the Funeral Direct. completely filled in by t	Medical C	29a. Certifier (Check only one)  29a. Certifying Physici 2 Medical Examiner								
	o the	Met	29b. Signature and title of certifier	10		29c. License	e number		29d. Date sig	gned (Month,	Day, Year)
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,	ह्य			leted cause of death (			S. Green	. (			
				nold, MI		25	J. Oneen	ear, s	zacni	cove , A	(4)
	Sta Registi		31. Date filed (Month, Day, Year)	32. Pogistrar's Si							

			For State Registrar		State of Ma	aryland	d / Depa <i>Cer</i>	rtment of	Health a of Death	and Me		ien <b>2</b> 0	07	28342
	Physici		1. Decedent's Name Patrick		_{st)} Jose	ph		Boy1e			Date of Deat Month	Day	Year	3. Time of Death 2:30 P M
	/Medio Examin		1610 Thomas 5. Social Security Nu	Road mber 6. S	e street and number) Sex MM 2 □ F 8	e (In yrs. la	est birthday)	4b. City, Town Ft. Was If Under 1 Ye Months Da	ar If Under		Date of Birth (Month, Day, Ug. 22,	Princ	nty of Death ce Geor	ge's
· Me	Director		578–42–1689 Usual Residence of D	Decedent	<b>Ž</b> M 2□ F 8		Yrs.		, , , , , , , , , , , , , , , , , , , ,	At	ug. 22,	1923		Ireland
	Marylar f show	lor		10b. County Prince Geo	orge†s		Town or Loo Washing							10d. Inside City Limits 1 ☐ Yes 2 No
	with the	Director	10e. Street and Num 1610 Thoma	ber				10f. Zip Cod	20744		11	og. Citizen o		untry?
5-0036	J within 72 hours after death with the Maryland jien. I then "natural", or Iteme 23a or 28a-f ehow I'm Medical Examination must be notified at	by Funerai	11. Marital Status  1 Never Marrie  3 XXVidowed 4	d 2∏ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ₹ ↑ If Yes, Give Year or Dates:		"	Vas Decedent of Yes, specify C	of Hispanic Original Juban, Mexican	gin? (Specif n, Puerto Ric	fy Yes or No- can, etc.)	14. R	lace - Amer	ican Indian, , etc. ite
0-61212	vithin 72 ne. han "nat	Completed	(Specif Elementary/Secon 12	15. Decedent's E y only highest gra dary (0-12)	ducation ade <i>completed)</i> College (1-4or 5	+)	16a. Deced (Give life. L Plui	ent's Usual Oc kind of work do OO NOT use re nber	cupation ne during most ired)	t of working		16b. Kind of	Business/l umbing	ndustry
yland	ild be file lental Hy ked othe ic event,	To Be C	17. Father's Name (F Edwa						18. Mothe		First, Middle, M Moriarty	Maiden Sum	ame)	
Mary	d 2 shou th and M 17 le mar traumat	-	19a. Informant's Nar Maureen Boy	ne/Relationship (	Type, Print)				et and Number	er or Rural P	Route Number,	-	vn, State, Z. 20602	ip Code)
Baltimore,	permit. Pages 1 and 2 should be tiled w bepartment of Health and Mental hygie Important: If Itam 27 is marked other traumatic event, ID once.		20a. Method of Dispo	sition	Removal from State	Ce	ace of Dispo: metery, cren	sition (Name of natory or other Cemeter	place)	Date 8/23/20	9	20c. Location,	n - City or 1	
Bail	permit. Departi		21. Signatur un	erat Service/Lice	ZII.				dress of Facility Hill Roa					
5 10 10	Physician /Medical		23a. Party Enter the shock, or heart Immediate Cause (disease or condition resulting in death)	inal		eno.	sclew		tying, such as				AIK	Approximate Interval Between Onset and Death
g/pn,	physician and by sithe burial-transit	dicai Examiner	Sequentially list con- if any, leading to imr- cause. Enter Underl Cause (Disease or in that initiated events resulting in death) La	ying njury	b. Due to (or as a c. Due to (or as a c.	a conseque	ence of):							
O. Box 62	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent   in the past 12 n 1  Yes 2  9	nonths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3□	Ectopic pregna Other (specify					Date of deli	very Day Year
cords, P.	law requires that the de as been signed by the a 2 should be detached f	ρ	Part II. Other signific	cant conditions	ontributing to death bu	ıt not resul	lting in the ur	derlying cause	given in Part I.		23e. Did tob			the cause of death?
Z Z	The ate hi	Completed								_		y ned? M⊇No	prior to c death?	topsy findings available completion of cause of
1 VII	Phyaicien: r this certific ral director,	To Be	25. Was case referre examiner?  1 X Yes 2 N		Ho <i>s</i> pital: 1 ☐ Inpatie	nt 2 □ E	R/Outpatien	3□ DOA	Othor		Check only on		Other (Spec	nfy)
	g ege	Certification:	27. Manner of Death  1 XNatural  2 ☐ Accident  3 ☐ Suicide	5 Pending investigation 6 Could not b		Year)	28b. Time of Injury	M 1	njury at Vork? □ Yes 2 □ t	No	d. Describe ho			
2	ital or At urs after o ral Direc		4 🗌 Homicide	determined	building, etc	. (Specify)		•			City or Town	, State)		ral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical	one)	Medical Exar	nysician: To the best on the basis of and manner sta	examination	/ledge, death on and/or inv	occurred at the estigation, in m	time, date and y opinion, deat	d place, and th occurred	at the time, da	ate and plac	e, and due	to the cause(s)
ı	Twith	Σ	29b. Signature and ti	tle of certifier				290.10	1943	3/	29	od. Date sign	ned (Month	n, Day, Year)
	(10)		30. Name and address	ss of person who	completed cause of de	DIC		STON (	(+103	177.	WAS	high	WM	0 20144
	Sta Registr	-	AUG 2 1 2		32. Registra	r's Signatu	ure /			1-1		0		

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 28343 State Registrar Amend 17, perInf, ©871,9/13/07 TT Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2007 19% 12:27 AM David T., Branch August 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Takoma Park Washington Adventist Hospital 8. Date of Birth (Month, Day, May 28, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Months Days Hours Washington, DC 1 X M 2 □ F 1934 73 577-46-3387 May Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1X Yes 2 No Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14136 Whispering Pines Court #21 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 □ Never Married 2 □ Married Black 1 ☐ Yes 2 ☒ No Specify. 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Government Recreation Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roy Tomm **Gleveland** Clipper Juanita Branch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type. Print) Dawana Branch/ Daughter 14136 Whispering Pines Ct. #21, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Washington Nat'l Cem. 08/23/2007 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service Licensee 716 Kennedy St. NW, Washington, DC 20011 aused the drath. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car or as a constiguence of) Due to (or as a consequence of) Due to (or as a consequence of): . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

Items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, th. Medical Examiner must

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

Director

Funeral

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Completed

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the Maryland

/Medical

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MT

attending physician and for use as the burial-tran

Examiner Physician/Medical þ Completed Be

or Attending Physician: The law requires that the death certificate be executed as been signed by the a has t certificate funeral director, After To the Hospital or Attend within 24 hours after death To the Funeral Director: the filled in by

Division or Vital Records, P.O. Box 68760,

State Registrar

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings availab prior to completion of cause of death? 1 ☐ Yes 275 No 24a. Was an available 1□ Yes No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 20 No 2 ER/Outpatient 3 DOA Inpatient Medical Certification: To 27. Manner of Death te of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

29d. Date signed (Month, Day, Year)

and address of person who d

24 Registrar's Sign

31. Date filed (Month, Day).
AUG 2 1 2007

At ce

29b. Signature and title

State of Maryland / Department of Health and Mental Hygiene Amend Items 23a Pt I,II, 25e Princate of 872 110/30/07dhb verb 2007 28344 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Charles E. Bounds 2007 1315 15 August /Medical 4c County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number, Examiner lesbare Medie comico Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. if Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number 6. Sex **Funeral** Days 1**欠** M 2□ F 212-18-6331 9/30/1918 Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Salisbury Director Maryland Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21801 USA 1707 Upper Millstone Lane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No
If Yes, Give Army/
Year or Date Air Corp 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo white Specify: 2 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stock Broker Morgan Stanley 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Bounds Mary (unknown) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret B. Bounds/daughter 1707 Upper Millstone Lane, Salisbury, MD 21801 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/21/07 Parsons Cemetery Salisbury, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligen Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 (F) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Aspiration Beumonia Immediate Cause (Final disease or condition resulting in death) **Physician** PIRATORY Failur 25 /Medical Due to (o as a consequence Chronic Obstructive Pulmonary Disease Examiner ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine that the death certificate be executed Congestive Heart Failure burial-trar Due to (or as a consequence of) physician Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by law requires 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy 2 No Division or Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 1 Natural
2 Accident 5 Pending investigation the Funeral Director: Af 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P 2 cause of death (Item 23a) (Type, Print) Tenth ST Pocomoke City MD VI MP 305 gistrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	of Maryland / De	epartment of F Certificate of			2007	28345
	Physici	an	Decedent's Name (First, Middle, Last)  Down Local Charmon			1	2. Date of Death Month	Day Year	3. Time of Death 9:34 P.M
	/Medio		Dora Lea Chapman  4a. Facility Name (If not institution, give street and r	number)	4b. City, Town, o	r Location of Death	August	23 2007 4c. County of Death	<del></del>
	_Xaiiiii	Ŭ.	Garrett County Memoria	1 Hospital	0aklano			Garrett	
	Funeral Director	(CE	5. Social Security Number 6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. last birth	Months Days	Hours Min.	Date of Birth (Month, Day, Y)  Jan. 25.	ear) Cou	place (State or Foreign Intry) 11and
	pg *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		-		10d. Inside City Limits
	Maryla 1 sho	ŏ	MD Garrett	Kitzmil					1 □ Yes 2 🔯 No
	r 28a-	Director	10e. Street and Number		10f. Zip Code		10g	J. Citizen of What Cou	intry?
	th with	a D	1042 Shallmar Road		21538			nited Star	es
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other treumatic event, the Medical Examinar must be notified at ODEs.	by Funeral	11. Marital Status  1 Never Married 2 Married 1 Yes, 3 Widowed 4 Divorced 12 Was Divorced	ecedent Ever in U.S. Forces? s 20 No Sive Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No		ify Yes or No- can, etc.)	14. Race - Amer Black, White Specify:	
9	72 hou	Completed by	15. Decedent's Education (Specify only highest grade complete	16a. [	Decedent's Usual Occup	pation during most of working	16	b. Kind of Business/li	
2	ithin 7	mple	Elementary/Secondary (0-12) College	(1-4or 5+)	Give kind of work done life. DO NOT use retired	d)		Social Se	erri coc
2	Hygier ther ti	S	12 17. Father's Name (First, Middle, Last)	c.i	erk	18. Mother's Name (	First, Middle, Ma		rvices
Maryland 21215-0036	uld be i Aental I rked o	To Be	Oscar Brady			Alice Leci			
lar)	2 sho and l	i N	19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street) 32 Shallma				ip Code)
e,	1 and Health em 27		Brenda Sherwood, Daugh 20a. Method of Disposition		Disposition (Name of , crematory or other place			oc. Location - City or 1	own, State
DE L	ages ent of ht: If it y or o		1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	III State	, crematory or other plac r1and Crema		/07 (	Cumberland	, MD
Baltimore,	mit. F partme porter y injur		21. Signature of Funeral Service Licensee	, Guinbe		ss of Facility Burdock F			,
<u> </u>	permi Depa impo		Harrid A. Bur	dock	710 Chur	ch Street,	Kitzmil	ller, MD 2	
	Physician		23a. Part f. Enter the disease, or complications that shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	t caused the death. Do no n each line. erebrovascula			respiratory arres		Approximate Interval Between Onset and Death one hour
ı	/Medical Examiner		Due Due	to (or as a consequence of	r):				
0,	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	to (or as a consequence of					
8760,	physic physic the bu	dical	d.						
P.O. Box 6	Physician: The law requires that the death certifica this certificale hes been signed by the attending phral director, page 2 should be detached for use as it.	Physician/Med	in the past 12 months?	outcome of pregnancy e birth 2   Fetal death gnant at time of death known	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of deline	very Day Year
	rulres that n signed b	۵	Part II. Other significent conditions contributing to hypertension	death but not resulting in	the underlying cause gr	ven in Part I.		cco use contribute to	
Records,	rhe law require te hes been siy age 2 should t	Completed	cigarette dependency				24a. Was an autopsy performe	prior to d	topsy findings available omptetion of cause of
<u>ta</u>	ian: i	BeC	25. Was case referred to medical examiner?			26. Place of Death			
<u>&gt;</u>	hysic this ce al dire	ို	1 Yes 2 No Hospital:	☐ Inpatient 2 ☐ ER/Out		4   140131119 110111		ce 6 ☐Other (Spec	cify)
ou	ding P. h. After i funera	tion:	1 Natural 5 ☐ Pending (M	te of Injury 28b. Ti onth, Day Year) Inj	jury Wo	ryat rk? ]Yes 2 □No	3d. Describe how	injury occurred	
Division of Vital	l or Attending after death. Director: After in by the fune	Certification;	3 Suicide 6 Could not be 28e. Ptg	ace of Injury - At home, farr itding, etc. (Specify)			Bf. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
_	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	edicai C	29a. Certifier (Check only one)  Certifying Physicien: To the and m	the best of my knowledge, a basis of examination and anner stated.	death occurred at the tile or investigation, in my o	me, date and place, ar opinion, death occurred	nd due to the cau d at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
	Vithin To the comple	Me	29b. Signature and title of certifier		29c. Licens	se number	290	d. Date signed (Month	n, Day, Year)
	-		I fal de theline	L M	D D002	.7205	(	08/24/2007	
		3	30. Name and address of person who completed completed to Karl E. Schwalm, M		Type, Print) Ourth Stree	t Oakland	, MD 2	1550	
Ž,	Sta Regist		31. Date filed (Month, Day, Year) AUG 2 4 2007	. Registrar's Signature	Sort			n	

State of Maryland / Department of Health and Mental Hygien 2007 28346 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year .00 PM **Physician** W. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Wester If Under 24 Hrs. 8. Da moran Maron If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 2□ F Months Days Min Yrs 218-30-015 Director 10/28/ Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Itema 23a or 28a-f show other treumatic event, the Mudical Examples must be exhibited at 1 Yes 2 □ No Director Allegany Westernport Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 25701 Shady Lane S.W. 21562 by Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 XYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours effer and Mental Hygiene. Is marked other than "natural", or Item 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ethel Durst John Cutter 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health and Importent: If Item 27 is rr eny injury or other treum once. Kathy Cutter - Sister 14233 Cunningham Drive S.W., Cresaptown, Maryland, 21505-5312 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 30, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State **Cumberland Crematory** Cumberland, Maryland 4 □ Donation 5 □ Other (Specify) 2007 22. Name and Address Picchnorn-McKenzie Funeral Home P.A. 21. Signature of Funeral Service Licensee Maken 2 8 East Main Street, Lonaconing, Maryland 21539 23a. Parl . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** minutes (dente My ocardial disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ierel Director: After this certificete has been signed by the attending physicien and filled in by the funeral director, page 2 should be detached for use as the buriel-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, lowney a lestrulive 1 Yes 2 No 3 Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rmed / 2.2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification; 28b. Time of 28d. Describe how injury occurred al or Attending P s after death. it Director; After 1- Matural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Hospitel o 24 hours aft Funerel DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely To the I within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 021244 +I VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAN Brondway 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State AUG 29 2007 Registrar

the

6001 Muncaster Mill Rd. Rockville, MD 20855 iegistrar's Signat 31. Date filed (Month, Day, Year) AUG 2 2007

Who

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

(Check only one)

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

August 19, 2007

Genevieve Wroblewski, M.D.

		í	For State Registrar	State of Maryland / Dep Ce	ertment of Health and I	Mental Hygien	
	Physicia	an	Decedent's Name (First, Middle, Last)	N/ C		2. Date of Death	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give stre	N. Culler	4b. City, Town, or Location of Death		5 <b>2007</b> 9:40 β.Μ c. County of Death
	Examili	<b>Э</b>	Alice Byrd Tawes	Mursing Home	Crisfield		Somerset
	Funeral Director	1	5. Social Security Number 6. Sex 125.07 - 3549	7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea 0 -0 - 1910	9. Birthplace (State or Foreign Country)
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
	Ba-1 eh	Director	MD Some	iset Mar.			1 Tyes 2 2(No
	th with the 23a or 24	al Dire	8708 Hudson	Corner RD	10f. Zip Code 21838		Citizen of What Country?
036	s 1 and 2 should be filed within 72 hours atter death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23a or 28a-d show other traumatic event, the Medical Examinar must be notilled at	by Funeral	11. Marital Status 12  1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 ☐No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	thin 72 ho e. en "natur Medical	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	ompleted) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired.		Kind of Business/Industry
d 21	filed withi Hygiene. other than		17. Father's Name (First, Middle, Last)		Laborer 18. Mother's Nar	me (First, Middle, Maide	
/lan	12 should be filed won and Mental Hygie fis marked other traumatic event, In	To Be	J. Thomas Cu	llen	OH:	e M. M	Lhittington
Maryland	12 sho h and h 7 is ma trauma	i u	19a. Informant's Name/Relationship (Type	0	ling Address (Street and Number or Re	00 11	
	permit. Pages 1 and 2 Department of Health Important: If Item 27 i eny injury or other tri once.	1	20a. Method of Disposition	20b. Place of Disp	obsition (Name of ematory or other place)		Location - City or Town, State
Saltimore,	permit. Pages Department of I Important: If It eny injury or or once.		1  Burial 2  Cremation 3  Ren 4  Donation 5  Other (Specify)	Hopewell	Cometery 08-		risticia, MD
Bal	permit Depar Impor eny in		21. Signature of Funeral Service Licensee		22. Name and Address of Facility And 314 Cove ST. Cri		
*	*		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. Do not el			Approximate Interval Between Opset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	Acure		webs
- X	Examiner		Sequentially list conditions, b.	Crincol	some ST	enoses	gens
	ned I	Examiner	arrany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
0,	ate be executed hysicien and the burial-transit	Exa	that initiated events c. resulting in death) Last	Due to (or as a consequence of):			
68760,	ate hys	edical	d.				
.O. Box (	The law requires thet the death certitics are has been signed by the attending propage 2 should be detached for use as it	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
0	iuires thet the signed by alid be detac	d by Ph	Part II. Other significant conditions contr	buting to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?
of Vital Records,	e law requir has been si je 2 should	Completed by				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
a R	ician: The certificete h rector, page					performed?	death?
V.	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	spital:	0	ath (Check only one)  Home 5 Residence	6 Other (Specify)
n of	ding Phys n. After this funeral di	Di: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how in	
Division	l or Attending after death. Director: After I in by the fune	ficati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm,	M 1 Yes 2 No	28f. Location (Street	and Number or Rural Route Number,
Ω	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificete has completely tilled in by the funeral director, page 2	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	•	City or Town, Sta	ate)
	Hospi 24 hou Funer etely till	Medical		r: On the best of my knowledge, dear: On the basis of examination and/or and manner stated.			
	To the within To the comple	Me	29b. Signature and little of certifier	Office do	29c. License number	29d. C	Date signed (Month, Day, Year)
			30. Name and address of person who dom	(1=5)	e, Print)	1. hon 0	ascral um
6	EB Sta	ate	31. Date filed (Month, Day, Year)	32. Regirar's Signature	(e) use u	igus y	20017
3	Regist		AUG 2 0 20	107 Dean &	Sports		007
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ORIGINAL

			FOF	ite of Maryland					ental Hy	giene		
			State Registrar		Cer	tificate of I	Death			Reg. No.	2007	28349
	Physicia	an	Decedent's Name (First, Middle, Last)	0 11					<ol><li>Date of De Month</li></ol>	ath Day	Year	3. Time of Death
	/Medic	al	Brandi	Cullen		Ab City Town or	- Lanation o		August	18	2007 ounty of Death	7:13 AM
	Examin	er	4a. Facility Name (If not institution, give street a			4b. City, Town, or	Mor		itu		1timore	
	Funeral		5. Social Security Number 6. Set	7. Age In yrs. la	ast birthday)	if Under 1 Year	if Under	24 Hrs.	8. Date of Birt	th	9. Birthpl	ace (State or Foreign
	Director		214-35-2926 1 th M 2	<b>⋉</b> ⊧ 15	Yrs.	Months Days	Hours	Min.	02/01/	y, Year) 1992	Mary	land
	pu ,		Usual Residence of Decedent  10a, State 10b, County	100 Ciby	, Town or Lo	nation					140	Od. Inside City Limits
	shov shov	'n	Toa. State Tob. County								"	1 Yes 2 No
	the M 28a-f	Director	MD Somerset  10e. Street and Number	Dea	al Isl	and 10f. Zip Code				10a Citize	n of What Coun	1
	with Ba or t be r		23680 Deal Island F	Pond			1821			rog. Onizo	USA	
	ms 2	Funeral	11 Marital Status 12, Wa	as Decedent Ever in U.S	3. 13. \	Vas Decedent of H f Yes, specify Cuba		igin? (Spec	cify Yes or No	- 14	. Race - America	
õ	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Exa <u>miner must be notified at</u>		1 Never Married 2 Married 1 [	med Forces? □Yes 2X No /es, Give		r Yes, specily Cuba I∐ Yes 2∭ No	an, mexicar Specify:		tican, etc.)		Black, White, e	
2-0036	hours tural	ed by		ar or Dates: *	16a Decer	lent's Usual Occup	ation				Whi	
Ċ	of fled within 72 h Il Hygiene. Other than "naturent, the Medica	Completed	15. Decedent's Education (Specify only highest grade comp		(Give	kind of work done of NOT use retired	durina mos	t of workin	g	TOD. KING	Of Business/file	ustry
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פַ	be filectial Hygel double control	BeC	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	(First, Middle,	Maiden S	urname)	
Maryland	Duld b Menta arked aric e	To	Edward Christopher (		1				e Spro			
Jar	S S S		19a. Informant's Name/Relationship (Type. Pr. Rita Marie Cullen/Mot	•		g Address (Street Deal Is						
_	1 and 2 Health em 27 I		20a. Method of Disposition			sition (Name of natory or other place			ate		ition - City or To	
Baltimore,	permit. Pages. Department of I Important: If ite any Injury or of		Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	ai irom state		natory or other plac . Cemeter		8/24/	2007		ess Ann	
	mit. F portme r Injur	1	1. Signature of Fune/al Service Licensee	Dee		. Name and Addre			2007	112110		<b>C,</b> 110
ñ	any per	(	unes I (Verman	M00295		nman Func			Princ	ess A	nne. MD	21853
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death	. Do not ente	er the mode of dyir	ng, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
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	/Medical Examiner	- 4	resulting in death)	Due to (or as a consequ								
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	uted i ansit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
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j	The law requires that the death certificate has been signed by the attending I hage 2 should be detached for use as	Physician/Me		JUnknown	aun 5							
J.	that ned by deta		Part II. Other significant conditions contributi	ng to death but not resu	lting in the ur	nderlying cause giv	en in Part I	l.	23e. Did t	obacco use	e contribute to th	e cause of death?
Records,	w requires that s been signed to should be deta	Completed by	Acute respiratory dist	ress syndro	me				1 🗆 '	Yes 2.∭	No 3 ☐ Prob	ably 4 □Unknown
ပ္ပ	law re as bee 2 sho	plet	Metastatic Ewing's sa	rcoma					24a. Was		24b. Were autop	osy findings available inpletion of cause of
		Com	SIP Bone marrow tran	solant					perfo	rmed? 2 ☐ No	death?	2 ☑ No
Vitai	sician: certific irector,	Be (	25. Was case referred to medical examiner?					of Death	(Check only o	ne)		
0	الق الق	5	1 ☐ Yes 2 ☑ No Hospita 27. Manner of Death 28a	a. Date of Injury	ER/Outpatien		4 LI NU		ne 5 Resident		Other (Specify	)
0	ding P. h. After i	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wor	k? K? Yes 2□		dd. Describe i	now injury	occurred	
DIVISION	Atten r deat ector: by the	fica	a Cuiside 6 Could not be	Place of injury - At ho	me, farm, str	eet, factory, office		2	8f. Location (	Street and	Number or Rura	I Route Number,
S	tal or s afte al Dir	Certification:	4 [] Horridge	building, etc. (Specify	, 				City or To	wii, State)		
	Hospit 4 hour Funer ely fill		29a. Certifier (Check only  1 ☑ Certifying Physician 2 ☐ Medical Examiner: C	n the basis of examinat								
	To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical		nd manner stated.		29c. Licens					signed (Month,	
	F > F 8		Kiton	el	_		-00	0				
•			30. Name and address of person who complet	ed cause of death (Item	23a) (Type.	Print)				, aga	st 18, 6	-UV T
_	4 EB		Kristen Nelson IMO	600 Nor	th Wol	fe Street	В	x Him	ore, M	orylar	d 212	-27
	Sta		31. Date filed (Month, Day, Year)  AUG 2 2 200	ed cause of death (Item  ON Nor  32. Registar's Signat	ture	Land.						
	Registr	1317	AUU 4 4 (UU		45	100 miles						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 0 0 7

Certificate of Death Reg. No. 28350 1 - State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 5:32A M AUGUST 2007 WALTER ANDERSON COLES /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES PRINCE GEORGES HOSPITAL CENTER CHEVERLY 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months XXM 2 F 73 24, 1933 WEST VIRGINIA Director 225 38 7494 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r than "natural, or Items 23e or 28s-f show the Madical Examination rotified at XXYes 2 □ No MD PRINCE GEORGES SUITLAND Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4707 MEDORA DRIVE 20746 UNITED STATES Funeral filed within 72 hours after death Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2/∑No If Yes, Give Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH SUPERVISOR FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ROSIE THOMPSON CHARLES COLES other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) SUITLAND, MD 20746 4707 MEDORA DRIVE ALMA COLES / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of the Important: If ite any injury or of once. XX Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) WASHINGTON NATIONAL CEM. 8/24/07 SUITLAND, MD Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, 4308 SUITLAND ROAD SUITLAND, MD 20746 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardiae arrhythmea Satal **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of). Examiner or Attending Physicien: The law requires that the death certificate be executed burial-trans Due to (or as a consequence of) attending physicien Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 Yes 2 No funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 ☐ Yes 2 🔀 No 3□ DOA Certification: To 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) After Injury 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No nours after death.

nerel Director: A
filled in by the fu investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 8-20-01 Chenerly, And 20185 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dute 3001 HOS Dary 31 Date filed (Month, Day). 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2007 9:00 AM 20 August Conveilt Cox/Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 7 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sea Birthplace (State or Foreign Country) Funeral Days Hours 1 ☑ M 2 ☐ F Dec. 1955 Guyana Director 51 214-43-7894 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner miss because once. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1X Yes 2 No MD Prince George's Bladensburg Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20710 U.S.A. 4245 50th Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No 1 ☐ Yes 2/☑ No Specify Black þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Store Clerk Private 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hyacent Robinson Cecil Cox ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4245 50th Place Bladensburg, Maryland 20710 Roxanne Cox/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Harmony Cemetery 8/24/2007 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licenses 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Massive Stroke Physician /Medical Due to (or as a consequence of) Examiner Thrombocytopenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Hypertension and the burial-tran Due to (or as a consequence of) attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by should be 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an page 2 autopsy performed? this certificate 1∐ Yes 2X No 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2**X** No 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 ☐ Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral L 29a. Certifier Kortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

6 BY

31. Date filed (Month, Day, State Registrar

Rama Kapoor M.D. 1500 Forest Glen Road Silver Spring, Maryland 20901 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**p**rtifier

29b. Signature and title

Division or Vital Records, P.O. Box 68760,

29c. License number

D64189

29d. Date signed (Month, Day, Year)

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dorsey Elizabeth Aug 2007 3:05 A^M 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mt. Airy
If Under 1 Year | If Under 24 Hrs. Lorien Nursing Home <u>Carroll</u> 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Director 215-20-8130 86 Feb 28 1921 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be not the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the Director 1XYes 2 No MD Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 713 Midway Avenue 21771 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Yes 2 No Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Her Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles ၉ Fleming Josephine Sellman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond N. Dorsey Spouse 7115 Woodbine Road, Woodbine, MD 21797 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Garden Aug 22 2007 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burrier-Queen Funeral Home nature of Funeral Service 21. Sig 1212 W. Old Liberty Rd., Winfield, MD Part1/Enter the disease, or complications that caused sho x, or heart failure. List only one cause on each e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innertal director, page 2 should be detached for use as the burial-transit completely filled in by the Innertal director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No autopsy 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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2007

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	Physicia		1. Decedent's Name (First, Middle, Last) Brünette Dunkley							1	2. Date of De		200 ⁴ 7°	3. Time of 2002	f Death M
	/Medic Examin	er	4a. Facility Name (If not institution, given Holy Cross Hos	acility Name (If not institution, give street and number)  Oly Cross Hospital  4b. City, Town, or Location of Death Silver Spring						ng	Montgomery				
	Funeral Director			Sex 1□M 2\SiF				If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.			8. Date of Birth 9. Bi 9. Bi 9. Bi 9. Bi			irthplace (State ( County)	or Foreign
Maryland 21215-0036	d oth	ctor	Usual Residence of Decedent  10a_State 10b. County		10c. City, Town or Lo			Washington						10d. Inside City Limits	
			DC				wasnington							1 ☐ Yes	2 No
		ai Director	199-Street and Number NW		^{10f. Zip Code} 20001				1		10g. Cit	izen of What USA	Country?		
		To Be Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	1 Tyes 2 TNo			Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes 2️X No Specify:								
			(Specify only highest grade completed)				ive kind of work done during most of working a. DO NOT use retired)					Sb.Kind of Business/Industry			
			17. Father's Name (First, Middle, Last) Rucker Simpson						me (First, Middle, Maiden Sumame) I nKnown						
			19a Informants Name/Relationship Russell Dunkle	Type, Print) Y Jr,/	Son	19b. Mailii 17 U	ng Addres	. NW	Was	hing	Route Numb ton D	er, City o	or Town, State	, Zip Code)	
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		State Gre	Place of Dispo cemetery, cres EENWOC	matory or d C	other place emet	ery	8-31	-07	Bec	klev,	or Town, State	
Balti			21. Signature of Funeral Service Licensee  22. Name and Address of Facility Ronald Taylor II FH  108 W. North Ave., Baltimore, MD 2120									201			
1	Physician /Medical Examiner	edical resulting in death)  Due to (or as a consequence of):  Anemia									irrest,		Approxima Interval Be Onset and	tween	
Records, P.O. Box 68760,	or Attending Physician: The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physicit in by the funeral director, page 2 should be detached for use as the bu	Medical Certification; To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Pneumonia  C.  Due to (or as a consequence of):  d.											
			IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify)								23d. Date of delivery Month Day Year				
			art If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown				
										_	24a. Was auto perfe	ppsy prior to completion of cause of death?			
Vital			25. Was case referred to medical examiner?	28. Place of Death (Check only one)  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)											
o			1 ☐ Yes 2数 No  27. Manner of Death 1 월 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)  28b. Time of Injury Injury			f 28c, Injury at Work?		at 28		me 5 Hesidence 6 Other (Spec 28d. Describe how injury occurred		pecify)		
Division			2 Accident investigation 3 Suicide 6 Could not I 4 Homicide determined	be 28a Blace of laws. At home form street featons office						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	the Hospital hin 24 hours the Funaral hpletely filled											s)			
	To th within To th comp		29b. Signature and title of certifier D5 66 9 1							29d. Date signed (Month, Day, Year) 8-17-2007					
(	1384		30. Name and address of person who Ghousia Sulta	na 121	of death (Ite 07 He	m 23a) (Type, ritag	e Pa	rk (	Circl	le Si	lver	Spr	ing,	MD 209	06
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 2	2007 J	strar's Sign	ature	March	۲,							

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State of Maryland / Department of Health and Mental Hygien 2 0 7

28354 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Robert Norman Dimmig 8:53P M August 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 367 Fletchwood Road Elkton Cecil 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Months Days Hours 333-44-3504 57 Director March 14,1950 Illinois Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland Cecil E1kton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 367 Fletchwood Road 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ¼Yes 2 □ No If Yes, Give Year or Dates: 1968-70 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Courier permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien Important: If Item 27 ie marked other tony injury or other traumatic event, the ODGs. Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willard Norman Dimmig Pauline Agnes Todd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shannon Dimmig/Wife 34 Cherry Lane, Elkton, Maryland 21921 20b. Place of Disposition (Name of cometery, crematory or other place)
R.T. Foard Funeral Home, P.A. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ACremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08-21-2007 Rising Sun, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility R.T. Foard & Jones, Inc. 122 West Main St., Newark, DE 19711 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a cor Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed ettending physicien end for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has t this certificate No. After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Certification: To 1 Yes 2 No 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending nere! Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title o 29c. License numbe M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOW STREET 106 JBRAMAMMU, ATHOK 31. Date filed (Month th, Day, Year) AUG 2 32. Régistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007 28355 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 19 **Physician** AUG. 2007 AISHA N. DALLAS 12:05P ^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 2/2/79 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year) 1 ☐ M 2 🛛 F 28 VIRGINIA 228-27-1087 Director Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If the firm 27 is marked other than "natural", or Items 23a or 28a-f show then than the traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County XX es 2 □ No Director FT. WASHINGTON PRINCE GEORGES MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2906 LUMAR DRIVE 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1√∑ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: BLACK 9 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 MEDICAL ASSISTANT MEDICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RUEBEN DALLAS JR. MAE MARSHALL ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4766 S. ZENO ST. AURORA, COLORADO 80015 RUEBEN DALLAS JR./FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Important: If iter
any injury or oth 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MT. COMFORT MEM.PK8/25/07 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility STRICKLAND FUNERAL SERVICES 21. Signature of Funeral Service Licenses 6500 ALLENTOWN RD. CAMP SPRINGS, MD enya 23a. Part1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Carthai arythi 47know /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) signed by the aid 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Neuropala 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 2XNo 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 nours after death.

neral Director: After this filled in by the funeral di 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8,20.07 043446

State

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Registrar AUG 2 2 2007

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROINTAN FARAHIFAR 9801 GEORGE

Ave Suit 3-41 Silver sping MD 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 15 2007 August 8:46 A Downer Marion /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 17551 Eleanor Lane Upper Marlboro Prince George's 8. Date of Birth (Month, Day, Yea Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7, Age (In vrs. last birthday **Funeral** Hours Min 1 □ M 21XF Jamaica 4, 1938 Director 220-37-1942 69 Mar. Usual Residence of Decedent a or 28a-f show t be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Pasadena Anne Arundel MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with in nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or?
Inty or other traumatic event, the Medical Examiner must be in USA 21122 1615 Carnoustie Dr. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XNever Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Day Care Provider Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Icy Townsend Sybil Ewan ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keisha Downer / daughter 1615 Carnoustie Dr. Pasadena, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 □ Burial 2 □ Cremation 3 □ Removal from State Burnt Ground Fam. Lot 09/01/2007 Santa Cruz, Jamaica 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service License Bowie, MD. CH 6512 NW Crain Hwy. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending p 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No led by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No page 2 s autopsy performed? certificate 2 No 1∐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) sister's Other: 4 Nursing Home 5 Residence 6 Other (Specify) home 1 ☐ Yes 2 ☑ No ٩ 1 | Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: **Hospital or Attending** Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: A d in by the f 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide in 24 hours the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

completely To the within 2 De

State Registrar 29b. Signature and title of certifier

AUG 2 1 2007

Glen

M

31. Date filed (Month, Day, Year) 32. Registrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

Jacob

29c. License number

1221 Mercantile Lane Larga.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 236 state of Maryland / Department of Health and Mental Hygien 2007.

Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Auc 0125 2007 Bowden /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Regional Medical Center

[6. Sex 7. Ago (In yrs. last birthday)] Wicomico Birthplace (State or Foreign Country) 5. Social Security Number 1 □ M 2 1 F Yrs. <u>aa7-a0</u> 70098 0-12-1918 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director hincoteaque ccomack 10e. Street and Number 10f. Zh Code 10g. Citizen of What Country? .S. A. 23336 Funeral LING 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married þ 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hairdresser 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bowd Murie Har Ker Brynolds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Kuby Del mar mo 21875 20c. Location - City or Town, State Brubaker Sister-In-Law 21875 20a. Method of Disposition Date 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Snow Hill Cometery 8/18/07 ^¹ 4 □Donation 5 □ Other (Specify) Whatcoat MO 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chincoteague, NA 2333L amanda Both Solver Funzial Home, Inc. (-6327 Church St 23a. Part1. Enter the disease, or complications that caused the death. Do not an er the mode, if shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 050 ue to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 😾 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

/Medical Examiner and I-transit or Attending Physician: The law requires that the death certificate be executed attending physicien a I for use as the burialed by the a signed b Division of Vital Records, been signature bround b page 2 this certificate

After

**Funeral** 

Director

or 28a-f show

or iteme 23a

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permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tem 27 is marked other then "na any injury or other traumatic awant and once."

Physician

other traumatic event, the Medical Exercise must be notified at

filed within 72 hours after

Baltimore, Maryland 21215-0036

Examiner Physiclan/Medical Completed by Be

Medical Certification: To To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death.

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

State Registrar

6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29h Signature and title of certifier

29c. License number

St

Salis

bury

1 Tes

2 No

29d. Date/signed (Month, Day, Year)

an 30. Name and address of person who completed cause of death (Item 20a) (Type, Print)

Benjamin
31. Date filed (Month, Day, Ye Meyerm D 16 100 E

5 Pending investigation

		Please Type or Print in Black Indelible Ink. Ensure		•									
		1 - State of Maryland / Department of Health and Certificate of Death	, ,	ene g. No. 2007	28358								
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/Med Exam	dical niner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of D		4c. County of Death Wicom									
Funera	al	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24		9. Birthpla	ce (State or Foreign								
Directo	or	215-20-4206   1 X M 2 F   80   Yrs.   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Hours   Months   Days   Months   Days   Hours   Months   Days   Months   M	12/9/19	Year) 126 Maryl	and								
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IMOre, Marylal Pages 1 and 2 should b ment of Health and Menti ant: If Item 27 is marked lury or other traumatic e		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Dolation 5 ☐ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Springfull Memory  Gardens	/24/07	Roc. Location - City or Town Hebron, MD	1, State								
Baltimore, permit. Pages 1 and Department of Heal Important: If Item 2 any injury or other	ouce	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Holloway Funeral 501 Snow Hill Ro	Home Prof	essional Ass ry, MD 21804	ociation								
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I HECONDS, P.O. BOX 6870.  The law requires that the death certificate to the has been signed by the attending physic age 2 should be detached for use as the L.	Physician/Medic	23b. Was decedent pregnant in the past 12 months?  1	23d. Date of delivery Month Day Year										
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DIVISION OF VITAI To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
To th To th	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)											
(MI)	A	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	10	121/0	/								
N. M	1,	Dr Simonz Eng 100 & Camil Street Salisbury MD	Dr Simone Eng 100 & Camil Street Salisbury MD 21801										
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

28359

Funeral Director

death with the Maryland show r 28a-f show notified at ms 23a or 7 an "natural", or items Medical Examiner mu 1 and 2 should be filed within 72 hours after al Hygiene. other than Health a permit. Pages 1 ar. Department of Heal Important: If Item 2 any Injury or other:

3altimore, Maryland 21215-0036

**Physician** /Medical Examiner

burial-trar the detached page 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Division or Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Voor 12:56 AM Ellis Gaylord L. Aua. 20 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 1 ☐M 2 ☐ F Oklahoma 75 1931 444-30-6122 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 □ No Director Prince George's Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12201 Shafer Lane 20720 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Xves 2 No If Yes, Give Year or Dates: Korea 1 Never Married 2 Married 1 ☐ Yes 2 【XNo Specify White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nat. Science Foundation Grants & Contract Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Bardwell Kenneth P. Ellis ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bowie, MD. 20720 Griselda I. Ellis / spouse 12201 Shafer Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 08/22/2007 Alexandria, VA. 21. Signature of Funeral Service Licen 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 000 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 **X**No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 13 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4403 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew S. Dobin, 4175 North Hanson Ct. Suite 203A Bowie, MD.

State Registrar

1019

M.D.

32. Registrar's Signatur

State

Registrar

SEP 0 5 2007

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 28361 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** Robert Gordon Fields, Sr. 0859 M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Regional Medical (ENTER Dolisbury Wicomico 8. Date of Birth (Month, Day, Year) 11/14/1931 Age (*In yr*s. Year If Under 24 Hrs. Days Hours Min. 9. Birthplace (State or Foreign **Funeral** Days Months 1**X** M 2□ F Maryland 215-26-5734 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Wicomico 1 □ Yes 2 □ X c Maryland Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 231 Cedar Way 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Mayes 2 No If Yes, Give AirForce Year or Dates AirForce 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: þ Specify. white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Civil Service Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sidney Fields Lillian Carey ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Elizabeth Fields/wife 231 Cedar Way, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory | 8/18/07 Salisbury, MD 21. Signature of Funeral Service Le 22. Name and Address of Facility Holloway Funeral Home Professional Association Kelf 501 Snow Hill Rd., Salisbury, MD 21804 awa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INTRACGREBRAL **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown tuneral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Ûnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1. Natural Injury thours after death.

uneral Director: A
ely filled in by the fu 1 Tes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af To the Funeral D completely filled in 29a. Certifier Larcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 VÁ D57331 on who completed cause of death (Item 23a) (Type, Print) CARROLL ST. SALISBURY Md. 21801 100 € IERRE MD 31. Date filed (Month) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner lisbur WICOMICO pastal Hospi ce a If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea DEC • 24 • 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number **Funeral** 1□ M 2ĂF Hours Months Days DELAWARE 82 DEC. 1924 Director 222-14-1961 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at SUSSEX SELBYVILLE DELAWARE 1 ☐ Yes 2 ☑ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19975 37767 SWANN DRIVE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TELLER BANKING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill treent of Health and Mental Hitant: If item 27 is marked oth Be 2 ERNEST H. JOHNSON ORPHA DUNLAP 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4126 WEBSTER RD., HAVRE de GRACE, MD 21078 MARILYN F. BROWN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or = 0 4 ☐ Donation 5 ☐ Other (Specify) ST. GEORGE'S CEMETERY AUG. 18, 2007 ST. GEORGE'S, DE 21. Signature of Funeral Service Licens 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 an 23a. Part Enter the disease, or complications that dused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on ach Immediate Cause (Final **Physician** tastatic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of) P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 don't 1 Yes 2 No 9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached the 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an s certificate has t irector, page 2 s Hospital or Attending Physician: nin 24 hours after death.

the Funeral Director: After this certific npletely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient ဥ 1 Tes 2 ER/Outpatient 3 DOA 27. Manner Death Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Detriying Physician: To the best of my knowledge, death occurred at the time, date any place, and due to the cause(s) and manner as states.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, the Signature and 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of ceath (Uem 23a) (Type, Print)

State Registrar filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 819 р м Robert Earl Fisher, Sr. 08/19/07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Kent Rock Hall 20780 BaysideAve 6. Sex 1 ☐ M 2 ☐ F 9. Birthplace (State or Foreign Country) D A If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 4/12/1925 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours PA 82 206-12-3660 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland ntal Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifited at 1 XYes 2 □ No Directo Rock Hall MD Kent 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21661 USA 20780 Bayside Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Aryes 2 □ No If Yes, Give Year or Dates: 42-46 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 Specify: Specify: Completed by White 3X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinest Paper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F Be Ethel Biddle Norman Fisher ပ္ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important; If item 27 Is any Injury or other tratonce. 20783 Bayside Ave Rock Hall, MD 21661 Sandra Coleman/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Cremation 08/21/07 Stevensville,MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Fellows, Helfenbein&newnam 21. Signature of Funeral Service Licenses Kick 130 Speer Rd. Chestertown, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final LUNG CANCER **Physician** METASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed use as the burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by CARDIOV ASCULAR ARTHORE SCLOROTTE 1 🗌 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No MELLITUS 24a. Was an aw has autopsy perform page certificate or Attending Physician: director, 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ D0A 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 2 this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 5 ☐ Pending investigation Division 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 29a. Certifier 1 Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier phatio 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/636 JAMES LACEY, MD GOLDSCORD 15 PAUROPA 32. Registraris Signature 31. Date filed (Month, Day, State AUG 2 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day 2001 /Medical he 4b. City, Facility Name (If not institution, give street and number) 4c. County of Death Examiner Town, or Location of Death town en hester. 25 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Months 2 □ F Director 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 □ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or by Funeral filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2XNo Specify: 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) than " College (1-4or 5+) is marked other 17. Father Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam 1 and 2 should be Health and Mental lationship (Type. Print) 19a. Informant's Name/F 19b. Mailing Address (Street and Number or Rural Route Number, permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai Method of Disposition

1 Burial 2 □ Cremation 20b. Place of Disposition cemetery, cremator Pages 1 3 □Removal from State 5 Other (Specify) Frineral Service Licen 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Appro imate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hupopharynaga
Due to (or is a confequence of): Cancer /Medical Examiner Sequentially list conditions, from the Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of that the death certificate be executed and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4□Pregnant at time of death 5 Other (specify) ed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 certificate has autopsy portarsion perform 2 No 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient Medical Certification: To this 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation **Hospital or Attending** Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗜 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner started. (Check only one) within 2. 29b. Signature and tiple of certifie 29c. License number 29d. Date signed (Month, Day, Year) D588 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year

32. Regist

2007

#### State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend, item#10a, b, c, e, fQACHDCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month **JEMISON** KING FLYNN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. If Under 1 Months 8. Date of Birth (Month, Day, Year) DEC. 19, 1929 Social Security Number Age (In yrs. last birthday) Year **Funeral** Days Hours 1**★** M 2□ F 77 Yrs **Director** 216-22-0309 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. Count 28a-f show Examiner must be notified at QUEEN ANNE MD QUEEN ANNE Director CULLFORD **SUMMERFIELD** NC 10f. Zip Code 21657 10g. Citizen of What Country? 10e. Street and Number 101 LAUREN WAY 5404 CHESTNUT RIDGE DRIVE ö <del>27358</del> or items 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be flied within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itel any Injury or other traumatic event, the Medical Examiner 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: <u>}</u> Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION CONSTRUCTION INSPECTOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be AGNES PICKETT JAMES ASHBY FLYNN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 LAUREN WAY, QUEEN ANNE, MD 21657 GARY FLYNN/ SON 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION STEVENSVILLE, MD 8-20-2007 CENTER 21. Signature of Funeral Service License 22. Name and Address of Fa FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Immediate Cause (Final prostate **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24a. Was an autopsy performe 2 X No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 2 ER/Outpatient 3 DOA 1 Inpatient completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural ∠ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

**ORIGINAL** 

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

Day

Year

9. Birthplace (State or Foreign

WASHINGTON, DC

USA

Black, White, etc.

WHITE

10d. Inside City Limits

Approximate Interval Between Onset and Death

MONTUS

1X Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

S. Washington St. Easton MS

			For State Registrar	State of Mary		artment of I rtificate of			giene Reg. No. <b>2</b> (	07	28366
	Physici /Medio		Decedent's Name (First, Middle, Last)     Lonnie Griffing					2. Date of De Month August	ath Day	Year 2007	3. Time of Death 6:25A M
	Examir		4a. Facility Name (If not institution, give southern Maryla	and Hospi		Clin				ce Ge	eorges
	Funeral Director		230-42-2847	7. Age (i	In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Biri (Month, Da June 2	th y, <i>Year)</i> 20 <b>, 1</b> 918	Coun	lace (State or Foreign try) Labama
	Maryland f show ed at	or	Usual Residence of Decedent  10a. State 10b. County  Md. PG	11	0c. City, Town or Lo	cation Suitlan	đ			1	0d. Inside City Limits 1 XYes 2 ☐ No
	with the I 3a or 28a- 1 be notif	I Director	10e. Street and Number 3601 Silver Par	k Drive		10f. Zip Code 20746		T	10g. Citizen of		•
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral		12. Was Decedent Eve Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13.		Hispanic Origin? (Sp pan, Mexican, Puerto			ce - Americ ck, White,	an Indian, etc.
21215-0036	rithin 72 hou ne. han "natura e Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of work	sing	16b. Kind of B	usiness/Ind	dustry
and 21	12 should be filed w n and Mental Hygiei Is marked other the raumatic event, the	To Be Col	17. Father's Name (First, Middle, Last)  John I. White	1		Cook	18. Mother's Nam	,	Maiden Surnai	vate ne)	
Maryland	1 and 2 shoul Health and M tem 27 is marl other traumati	T	19a. Informant's Name/Relationship (Ty Willie Stewart/		3601	Silve	t and Number or Rui r Park D Md. 2074	ral Route Numb	er, City or Town	, State, Zip	Code)
Baltimore,	Pages 1 annual of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval nom State	20b. Place of Dispo cemetery, crei Resurrec	sition (Name of matory or other pla	ace)	Date	20c. Location		
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	Halfe			ess of Facility Ho ver Hill	-			Md.20746
	Physician		23a. Part Enter the disease, or compl shook, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)		e death. Do not ent	er the mode of dy	ing, such as cardiac	10	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner	j.		Due to (or as a co							
M 7-	cate be executed oblysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a c							
68760,	certificate be Iding physicia Ise as the bur		(	d							
P.O. Box	w requires that the death certific, been signed by the attending pl should be detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf 1 □ Live birth 2   4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су			ate of delive onth	ery Day Year
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Division or Vital Records,	@ S C√	Completed						24a. Was auto perfo 1□ Yes	an 24b.	Were auto prior to co death? 1  Yes	psy findings available mpletion of cause of 211 No
Vita	certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Ot	26. Place of Dear				
on or	Attending Physician: r death. ector: After this certifica by the funeral director, I	ion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient  28a. Date of Injury (Month, Day Y	28b. Time o	f 28c. Inju	4   Nursing n		dence 6 □Ot how injury occu		iv)
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1215-0036	thour	ed b		t's Education	ates.	16a. Dece	dent's Usual Occup	ation			6b. Kind of Busine		
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7	be filed within 72 hours after death with the Maryland Hyglene.  id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a be notified at event, the Medical Examiner must be notified at	Be Completed	Elementary/Secondary (0-12)			Manage	ement				Food Ser	vice	
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	Licensee			2. Name and Addres	ss of Facility	Rest	Haven	Funeral	Chapel	
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2	oital o urs aft eral Di			1					4				- 4
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to	edical	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the Examiner: On the ba	best of my kno asis of examina ner stated.	wledge, death ation and/or in	n occurred at the time vestigation, in my op	ne, date and pinion, death	d place, and on the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of th	due to the cau t the time, dat	ise(s) and manner e and place, and	as stated. due to the cause	(s)
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	5		30. Name and address of person	who completed caus	e of death (Item	n 23a) (Type, I	Print)	. 8	2 )				/
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	Sta Registra		31. Date filed (Month Day, Year)	007 32. R	egistrar's Signa	iure force			-				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O 8 **Physician** Pawlemma /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury WICOMICO HOSPICE at The If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days 1 □ M 2 F Months Hours Director MARKAND and 2 should be filed within 72 hours after death with the Maryland eatth and Mental Hygiene. 10c. City, Town or Location 10a State 10d. Inside City Limits If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at Yes 2 □ No ELMAR Director 1 comico 10f. Zip Code 10g. Citizen of What Country' UNITED by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 D No
If Yes, give Year or Dates: Race - American India Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Saltimore. Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT, use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Be 19a. Informant's name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if Item 27 is any injury or other trauonce. 8807 Delmar, md 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) -24-07 elmar, DE 21. Signature of Ineral Service Licensee 917 W. Isaheila St Salishury, md 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 9 ☐ Linknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 10 Hospital: 1 Yes 2K No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 MOther (Specify) #05 pece 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M.

29505

BELLOSO, M.D.; 5302 CHINABERRYDR, SALISBURY, M.D. 21801

29d. Date signed (Month, Day, Year)

08-18-07

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene and

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State of Maryland / Department of Health and Mental Hygiene 28370 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 1:08 PM **Physician** Griffin 8 19 2007 Ruby /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Wicomico Parsonsburg 33281 Old Ocean City Road Birthplace (State or Foreign Country) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Hours 1 ☐ M 2 🖾 F Maryland 9-12-1930 Director 76 214-28-2842 Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County in than "natural", or items 23a or 28a-f show the Medical Exactly at must be notified at 1 ☐ Yes 2X No Wicomico Parsonsburg Direct 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21849 33281 Old Ocean City Road USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 White by 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) other than Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth eny linjury or other treumatic event ones. Be Linwood Webster Flossie 2 Hastings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pamela Truitt - daughter-in-law 33281 Old Ocean City Road, Parsonsburg, MD 21849 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Creamtory of Delmarva 8-24-2007 Delmar, Delaware 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CANCER **Physician** LUNG /Medical Due to (or as a consequence of): Examiner PIRATORY KES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit C of that initiated events ettending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 4 Pregnant at time of death detached been signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed 2 No this certificate 1 Yes Attending Physician: funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Manner of Death 28b. Time of After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō within 24 hours a 1 Techtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainted as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 08-20-2007 136847 Shelo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAZISBURY 21804 ME KHALIL 325 tAUZ1 4ER MON 31. Date filed (Month Peg Year) egistrar's Signature State 2007

Registrar

			For State Registrar	State of Mary		artment rtificate			d Ment		ene 0 (	7	28371
	Dharis		1. Decedent's Name (First, Middle, Last)							ate of Death	Day	Year	3. Time of Death
	Physici /Medic			Rafael	l Gonza				Auc	just 1			4:44 A ^M
	Examin	er	4a. Facility Name (If not institution, give st			4b. City,		ocation of D	eath		4c. County		
			Prince George's Ho  5. Social Security Number 6. Sex	+-	ter yrs. last birthday)	If Under		verly	Hrs. a n	ate of Righ	Anne		
	Funeral Director		671-26-1937 ¹ X	M 2□F	76 Yrs.	Months	Days		Ain. (A	ate of Birth fonth, Day, Y By 25,	1931		place (State or Foreign ntry) V.I erto Rico,
	land ow		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	ocation						T	10d. Inside City Limits
	Man,	į	Maryland   Prince G	eorge's			Bow	rie					1⊠Yes 2 No
	with the	Director	10e. Street and Number 12315 Stafford La	ne		10f. Zip	Code 207	16		100	g. Citizen of W	hat Cou	ntry?
	death	Funeral		2. Was Decedent Ever	in U.S. 13.	Was Deced		panic Origin' , Mexican, P	? (Specify Y	es or No-	14. Race	- Ameri	can Indian,
320	should be filed within 72 hours after death with the Maryland ut Mental Hygiene. Thygiene was the file of the than "nature!" or items 23a or 28a-f ehow marked other than "nature!" or items 23a or 28a-f ehow matic event, if a Medical Examinar natal be notilied at	by Fur	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	If Yes, spec 1 H Yes 2		0		Ricar		k, White,	etc. nite
ž	2 hou	ted	15. Decedent's Educ	ation	16a. Dece	dent's Usua	I Occupati	ion			6b. Kind of Bu		
	within 7	Completed	(Specify only highest grade Elementary/Secondary (0-12) 6 Lh	Completed) College (1-4or 5+)	life.	DO NOT us	e retired)	ring most of Operat		}	Di	civat	to
א ס	Hygie Hygie other			Unk		TITCAC				t, Middle, Ma	aiden Sumam	***	nk
/lan	g <u>a</u> <u>a</u> <u>a</u>	To Be											
<u>ā</u>	is 1 and 2 should of Health and Mer item 27 is marke other traumatic	2	19a. Informant's Name/Relationship (Type Cesar Mateo (Son-	e, Print) in <b>-l</b> aw)						te Number, ( Le MD	City or Town, . 20716	State, Zij	Code)
e e			20a. Method of Disposition		Ob. Place of Dispo cemetery, crea	osition (Nam matory or ot	ne of ther place)		Date	20	c. Location -	City or To	own, State
Ē	Pages ment of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Lakemont				8/22/				nville, MD
Rail	permit. Page Department Important: fi eny injury o		21. Signatur of Juneral Service License	Seul							Funera , MD 20		ome
			23a. P. (1. Enter the disease, or complic mock, or heart failure. List only one	ations that caused the	death. Do not en	ter the mode	e of dying,	such as car	diac or resp	oratory arres	it,		Approximate Interval Between
	nysician	-	disease or condition	Laroser	0515							9	Onset and Death
	/Medical Examiner		resulting in death) a.	Due to (or as a cor			(						
	77	Jer	Sequentially list conditions, I ary, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor		stech	1,104					-	
	nd nd transit	Examiner	that initiated events C.										
8/60,	ficate be executed physicien and is the burial-transit		resulting in death) Last	Due to (or as a cor	nsequence of):								
80	ificate g phys as the	edical	d.										
ŏ	leath certific attending p	an/M	23b. Was decedent pregnant	c. If yes, outcome of pro		∃Ectopic pre	egnancy				23d. Date		
o o	requires that the death certificate be executed teen signed by the attending physicien and hould be deteched for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□ Unknown		Other (spe				3.	Mor	ntn	Day Year
ນັ	res thet igned b		Part If. Other significant conditions cont		t resulting in the u	nderlying ca	ause given	in Part I.	2	23e. Did toba	cco use contr	ibute to t	he cause of death?
cord	w requir been si should	eted	Coronary artery	Distage					-		212No	3 Prol	bably 4 Unknown
ου.	e la has	Completed by	Shock liver				-		-	4a. Was an autopsy performe	ed?	rior to co	opsy findings available empletion of cause of
	sician: The certificate rector, pag	e e	dehydrittm 25. Was case referred to medical					26. Place of		Yes 20		∐ Yes	2□ No
> i	\$ 50 P	To B	examiner? 1 Yes 2 No	spital: 1 Inpatient	2 ER/Outpatier	nt 3□ DO	Other				ce 6 □Othe	er (Speci	<b>(</b> *)
	ing Afte une		27. Manner of Death  Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time o Injury	f 21	8c. Injury a Work? 1 □ Ye	at es 2⊡No	28d. [	Describe how	injury occurr	ed	
_	irec hrec	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farm, stroecify)	reet, factory	, office			ocation (Stre		er or Run	al Route Number,
ַ	e Hospital ( ) 24 hours al  e Funeral Dietely filled (		29a. Certifier Certifying Physi	cian: To the best of my	knowledge deat	h occurred :	at the time	date and o	lace, and d	ue to the cau	seale) and ma	nnor 25 6	hatet
	the Hos in 24 ho the Fun ipletely	Medical	(Chack ordy 2 Medical Examinations)	and manner stated.	mination and/or in	vestigation,	in my opir	nion, death o	occurred at	the time, date	e and place, a	ind due t	o the cause(s)
	To the within 2	ž	29b. Signature and title of certifier			29c	. License r			290	d. Date signed		,
	(1)		1 /1) 4	e mis			DO	00431	662		812	1107	7
لو	e		30. Name and address of person who con			Print)							
	Sta Registr		31. Date filed (Month, Day, Year)	32, Registrar's S	<del>/</del>								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year Physician Catherine Louise Gourdine 08 16 2007 5:30A /Medical 4c. County of Death Prince 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Clinton
If Under 1 Year | If Under 24 Hrs. Clinton Nursing Center Georges Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days 1 □ M 2 🕁 F Hours Min. Yrs Director 01-18-1946 Washington 548-64-3829 61 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County Prince 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Directo MD Georges Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14234 Greenview Drive 20708 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No specify: Black ð 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Technician Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Walters Louise Rundd ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14234 Greenview Drive Laurel, MD 20708 James Gourdine/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/22/07 Los Angeles, CA Inglewood 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 814 Franklin Street ٤ Greene Funeral Home Alexandria, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecuence Examine The law requires that the death certificate be executed sician and burial-tran-Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to de ot resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2/2 No death? 1 ☐ Yes 2 No 1☐ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 2 No 1 ☐ Yes 2 ER/Outpatient 3□ DOA 4 A Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

State

31. Date filed (Month,

(Check only one)

29b. Signature and title of certific

30. Name and address of pers

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 28373 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** MYRTLE DEFFIE HOBBS 08:18 A M 2007 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery General Hospital Olney Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Min 1 □ M 2 🔀 F 77 251-42-6917 Director July 12 1930 North Carolina Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits show 10a, State r 28a-f shov notified at 1 ☐ Yes 2 🖼 No Director North Hampton Henrico N. C. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ir than "natural", or items 23a or the Medical Examiner must be 28364 #5 Bob White Road United States death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: American Indian Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Bus Driver 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Deffie Down Deese Junie Brooks 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17601 Darnestown Road, Boyds, Md. Carl Hobbs 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/31/07 Colesville, Md. 4 □ Donation 5 □ Other (Specify) Colesville Cemetery 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee muriel 20882 Box 5038, Laytonsville, Md. P. O. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to influented cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 1 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2[JAKO 4 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Puneral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Rd. Clacksbulg MP 2087/. 10

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) SEP 0 5 2

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene o o

			1 - For State Registrar	Otato of Maryla	Cei	rtificate of	Death	R	leg. No.	17 28374
	hysicia		1. Decedent's Name (First, Middle, Las Mariba E	Hine				2. Date of Dea Month	Day Y	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deat		4c. County of	
				ice at the		Sau	sbury			mico
	neral ector		129-16-1644	ex 7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9 925	Birthplace (State or Foreign Country)  New York
and	T N		Usual Residence of Decedent  10a. State 10b. County	10c. 0	City, Town or Lo	ocation				10d. Inside City Limits
death with the Maryland	-r sno	tor	Maryland Wicomico	Sa.	lisbury					1 ¥Yes 2 □ No
th the	or 28a	Director	10e. Street and Number	) Da.	LIBBULY	10f. Zip Code		1	10g. Citizen of Wha	at Country?
ath wi	ust b		26239 Pemberton	Dr.		21801			USA	
er de	ner m	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 █ No	U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Black, 1	American Indian, White, etc.
2-0030 72 hours after	larked other than "natural", or nems 23a of 28a-1 show natic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 3 Married 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🕱 No	Specify:		Specify: V	
<b>Z I 3-</b> thin 72 h	Medica	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	i (Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wa	orking	16b. Kind of Busin	ess/Industry
d Z I Z I filed within Hygiene.	it, the		12	4	Homema	aker	46 14 11 1 1 1		Homemakir	ng
d be file	ed off	Be	17. Father's Name (First, Middle, Last) Harry Augustus Mc	orev			Martha	me (First, Middle, i		_
	matic	ဥ	19a. Informant's Name/Relationship (		19b. Mailir	ng Address (Street	<u> </u>	ural Route Numbe	Hedge r, City or Town, Sta	
4 2 a i	3 5		Patricia Mitchell/	'daughter	26329	9 Pembert	on Dr. S	alisburv	,Maryland	1 21801
or He	or other traum		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🖸	20b	Place of Dispo	psition (Name of matory or other place den Capit			20c. Location - Cit	
Pages tment of	jury o		4 ☐ Donation 5 ☐ Other (Specify	//   Pa	arks		: 8/2	2/07 P	flugervi	lle,Texas
baltimore, permit. Pages 1 an Department of Heal	any In	6 8	21. Signature of Funeral Service Liver	see CFSP	Ho	2. Name and Addre D110way F D1 Snow H	uneral H	ome Salisbur	y,Marylar	nd 21804
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oo / oo	the b	Medical		d						
. =	5, 60	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf preg					23d. Date o	of delivery
death	e alle	Physician/	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		□Ectopic pregnanc □ Other (specify) _	у		Month	
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law re	2 sho	Completed				-		24a. Was a	an 24b. We	re autopsy findings available or to completion of cause of
<b>L</b> af .	page,	Con						perfor 1∐ Yes	med?   dea	ith? Yes 2 <b>⊠</b> No
Or VII.all	rector	Be	25. Was case referred to medical examiner?	Hospital:		at 3D DOA Oth	or:	ath (Check only or		17
5 4 E	Arier mis cermicate has funeral director, page 2:	2	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time o	II DOA	4 LI Nursing I		ence 6 COther ow injury occurred	(Specify) Hospice
Attending r death.	e fune	atior	1 🗷 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rƙ?  Yes 2∐No			
al or Attendir	d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spec	home, farm, str cify)	reet, factory, office		28f. Location (S City or Town		or Rural Route Number,
To the Hospital or Attendi	etely fille	edical C		ysician: To the best of my k niner: On the basis of exami and manner stated.						
To the within	compli	Med	29b. Signature and title of certifier	7		29c. Licens	se number	2	29d. Date signed (/	Month, Day, Year)
	)		Sugario h	4. Belloss	Z. I	DZ	9505		08-18	7-07
Lak	/		30. Name and addless of person who	completed cause of death (It	em 23a) (Type,	Print)				

4 H

State Registrar

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17 28375 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Boyd Hudson August 18, 2007 11:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Alice Byrd Tawes Nursing Home Crisfield Somerset If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Months Days Hours Yrs Director 076-22-0599 09/15/1927 New York Usual Residence of Decedent the Maryland 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exempler must be notified at 1 Yes 2 □ No Directo Somerset Westover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 238 6457 Old Westover Road 21871 death by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 \( \text{No} \) No If Yes, Give Year or Dates: \( \text{1947-50} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced "natural" White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "na eny injury or other traumatic event, Itam Media once. Elementary/Secondary (0-12) College (1-4or 5+) none Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alan Hudson Elizabeth Agnew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara Anna Hudson/Wife 6457 Old Westover Road, Westover, MD 21871 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Calverton National Cem 08/23/2007Long Island, New York 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hinman Funeral Home 1. Signature of Funeral Service/Licensee Anne MD sa. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21853 Approximate Interval Between Onset and Death Atherosclerosis Immediate Cause (Final Physician disease or condition resulting in death) oronaui /Medical Due to (or as a consequen-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physicien and for use as the burial-transit The law requires that the death certificate be executed Exami resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this After thi 28b. Time of Injury 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D54422 8-18-2007 who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

2007

32. Registrar's Signature

201-Hall

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28376 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Bonnie Forest Hunt : 45 AM HUGUST 200 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death HOSPIta Ba Agnes Itimor If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days Hours Months 1 ☐ M 2 🛣 F 220-54-6252 57 Jan 13, Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Sykesville Carroll Maryland 1 ☐ Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21784 USA 633 Tanglewood Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify. Specify: 3 ☐ Widowed 4 🗷 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cashier/Pharmacy Clerk Grocery Store 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shirley Duval Henry Ehatt, Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 633 Tanglewood Drive, Sykesville, MD 21784 Kimberly A. Kruger, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Liberty Church Cem. 8/20/2007 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Myers-Durboraw Funeral M01191 91 Willis Street, Westminster, MD 21157 P3a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neta 420 Due to (or as a consequence of): Date to (or sels consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 1 ☐ Yes

**Physician** /Medical Examiner

Department or Important: If any injury or

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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"natural", or items 23a or edical Examiner must be

Pages 1 and 2 should be filed within 72 homent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natuury or other traumatic event, the Medical

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Funeral

Completed by

Be

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

The law requires that the death certificate be executed the burial-transi physician as for use page 2 should this Hospital or Attending

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Records,

Vital

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Physician:

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funeral director After within 24 hours after death.

To the Funeral Director: filled in by the

completely 3+5

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2**/A**No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2/21No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1/XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 Accident (Month, Day Year) Injury 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

<u>varole</u> 31. Date filed (Month, Day, Year)

MO 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

		•	For State Registrar	State of Maryla		ertificate of		R	eg. No. 2 A A	7 28377
, V	Physici		1. Decedent's Name (First, Middle, Las	HOSKII	VS			2. Date of Dear	th Day Year 13 200	i South
	/Medio		4a. Facility Name (If not institution, given 1245 Green Holls)	e street and number)			Location of Death		4c. County of Dea	
	Funeral Director		231-17-0700	7. Age (In y	ors. last birthd	Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 19	9. Bin C	rthplace (State or Foreign ountry) Virginia
	Maryland a-f show ffied at	tor	Usual Residence of Decedent  10a. State		City, Town or	Location	Annapol	is		10d. Inside City Limits 1 □Yes 2 ☑No
	th with the 23a or 28a ist be not	Funeral Director	10e. Street and Number 1245 Green Holly	Drive		10f. Zip Code	21409	1	0g. Citizen of What C	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 198		3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)		
Maryland 21215-0036	hin 72 ho e. an "natu Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5+)	l (G	cedent's Usual Occup ive kind of work done e. DO NOT use retired	during most of wo	rking	16b. Kind of Business	/Industry
d 21;	filed wit Hygiene other tha	Con	17. Father's Name (First, Middle, Last)	2		Hospita	al Corp 18. Mother's Nar	me (First, Middle, I	U.S. I	Navy
ylan	should be fand Mental Is marked of umatic eve	To Be	Willard Stanfor					ta Crum		
	and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship ( Edith D. Hoskins			ailing Address (Street 45 Green Ho				zip Code) yland 21409
Baltimore,	Pages 1 ament of He rant: If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	H		sposition (Name of crematory or other place Family Cer	metery 8	/17/2007		Virginia
Ball	permit. Departri imports any Inju		21. Signature of Funeral Service Licer	Jill dill	en				ylor Funera , Annapolis	al Home s, MD 21401
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	/Medical Examiner			Due to (or as a cons	sequence of):			,		
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Let	Due to (or as a cons	sequence of):					
68760,	tificate be executed ig physician and as the burial-transit		resulting in death) Last	Due to (or as a cons  d	sequence of):					
		Medical	IF FEMALE:							
.O. Box	The law requires that the death cer tte has been signed by the attendin age 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pre 1 Live birth 2 F 4 Pregnant at time of	etal death	3 ☐Ectopic pregnancy 5 ☐ Other <i>(specify)</i>	′		23d. Date of de Month	elivery Day Year
Records, P.	quires that en signed by uld be deta	þ	Part II. Other significant conditions	contributing to death but not	resulting in the	e underlying cause giv	en in Part I.	23e. Did tol	bacco use contribute e es 2 <b>/ N</b> o 3 ☐ F	to the cause of death? Probably 4 □Unknown
	The lar	Completed						24a. Was a autops perfort	sy prior to med? death?	autopsy findings available completion of cause of
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath (Check only on	*	
0	Phys r this ral dir	₽.	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpa 28b. Tim	tient 3 DOA Oth	4 □ Nursing F	_	ence 6 Other (Spoow injury occurred	ecify)
ion	Attending Physician: r death. ector: After this certifica by the funeral director, I	ation	1 Natural 5 ☐ Pending investigation	(Month, Day Year		ry Wor	k? Yes 2 □ No	200. 200201	on injury occurred	
Division or	al or Attus s after de al Directus ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - A building, etc. (Sp.	t home, farm, ec <i>ify)</i>	street, factory, office		28f. Location (Si City or Town	treet and Number or F n, State)	lural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (	29a. Certifier (Check only one)	nysiclan: To the best of my miner: On the basis of exam and manner stated.	knowledge, d nination and/o	eath occurred at the tir r investigation, in my c	me, date and place opinion, death occ	e, and due to the curred at the time, d	cause(s) and manner a date and place, and du	is stated. ie to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	120.	4	29c. Licens	,		29d. Date signed (Mon	th, Day, Year)
•	X	)	30. Name and address of person who	compoleted cause of death (	Item 23a) (Ty	pe, Print)	2143	4	- Augu	10,2007
	Sta	te	31. Date filed (Month, Day, Year)	39 Registrar's Si	gnature	) WEF	NSE F	TIGHWI	AN I NOT	
	Registr		AUG 2 0 200	37 Some.	K M	porte				

Please Type or Print in Black Indelible Ink. Ensure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ryland / [		ertment of He Etificate of D			iene eg. No. <b>2 ()</b>	7	28378
	Physici	an	1. Decedent's Name (First, Middle, La						2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic	al		rome Higd	on		4b. City, Town, or L	ocation of Death	August	4c. County of		10:34 A M
1	Examin	er	4a. Facilify Name (If not institution, giv 209 West Mill A					. Heights	5	Prince		orges
3	Funeral		Social Security Number 6. S	Sex 7. Age	(In yrs. last bir	thday)	If Under 1 Year					place (State or Foreign
	Director		3/9-30-6362	M 2□F	66	Yrs.	Months Days		April 2	6, 1941	Mash:	ington,D.C.
	ryland how lat	_	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Lo	cation				1	0d. Inside City Limits 1   Yes 2 No
	ne Ma 8a-f s ptiffed	Director	Maryland Prince	Georges	Capi	to1	Heights			0 02:614	had Cause	
	with the	Dire	10e. Street and Number 209 West Mill Av				10f. Zip Code 20743		1	Og. Citizen of W United		
	eath in 23, must	Funeral	11. Marital Status	12. Was Decedent E	ever in U.S.	13. \	Vas Decedent of Hisp f Yes, specify Cuban,		ecify Yes or No-	14. Race	- Americ	an Indian,
215-0036	ified within 72 hours after death with the Maryland II Hygiene. other than "natural", or items 23a or 28a-f show rent, the Mediral Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	lo			, Mexican, Puerto Specify:	Rican, etc.)	Black Specify:	B1	etc. ack
<del>ک</del>	72 ho 'natur dical	Be Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a.	Deced (Give	lent's Usual Occupati kind of work done du OO NOT use retired)	ion <i>ring m</i> ost of work	ing	16b. Kind of Bu	siness/In	dustry
7	filed within Hygiene. t <b>her than</b> "	Idm	Elementary/Secondary (0-12)	College (1-4or 5	+)		ofessional			Priva	- 0	
ס	filed Hygie	ပိ	17. Father's Name (First, Middle, Last	)		11,		8. Mother's Name	e (First, Middle, I			
an	9 5 3 5 6	To B	Richard Higdon					Helen H	Rose Pro	ctor		
, Maryland	and 2 should salth and Mer n 27 is marke ier traumatic		19a. Informant's Name/Relationship (Martha Ann Higd	• • • • • • • • • • • • • • • • • • • •			g Address (Street an West Mill		apitol H	eights,	Md.	20743
Baltimore,	SS 1		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Spe)		20b. Place of cemete Metro	ry, cirer	sition (Name of natory or other place) Ltan	8/23/		20c. Location - C	,	
Balt	permit. Page Department of important: if any injury or once,		21. Signature of Funeral Service Lice		0	22	Name and Address Alexander 5538 Mari	of Eacility Pope boro Pil	è/Forès	tville,	Md.	20747
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	/Medical		disease or condition resulting in death)	Due to (or as	consequence	of):	1 1150100		J			9,
	Examiner		Sequentially list conditions.	bHy	pertens	ron						15~
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as	consequence		Mites					9+
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28/60	icate be executed physician and s the burial-transit		(	Co	nees twe		heart fail	we				10 fr
_	tificate g phy as the	ledical					V					
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)			23d. Date Mor		ery Day Year
<u> </u>	that t led by detac		Part II. Other significant conditions		ıt not resulting i	n the u	nderlying cause given	in Part I.	23e. Did to	bacco use contr	ibute to t	he cause of death?
rds	iw requires that s been signed t should be det	ed by	Cardiomyop	othy					1 □ Y	es 2 No	3 ☐ Prol	bably 4 □Unknown
Vital Hecords,	sician: The law re s certificate has bee irector, page 2 sho	Completed		J					24a. Was a autops perfor	med? p	rior to co leath?	opsy findings available mpletion of cause of
<u>ra</u>		Be C	25. Was case referred to medical					26. Place of Deat				2010
o  -		To B	examiner? 1 ☐ Yes 2 🔀 No		nt 2 ER/OL			4 LI Nursing Ho	ome 5X Resid			fy)
	ding Phy n. After thi funeral (		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injui (Month, Day		Time o Injury	Work?		28d. Describe h	ow injury occurre	ed	
<u> </u>	r Attend ter death. Irector: /	cati	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e 290 Place of init	ırv - At home, fa	arm. str	M 1 ☐ Ye eet, factory, office	es 2□No	28f. Location (S	treet and Numbe	er or Run	al Route Number,
DIVISION	tal or Attencrs after death al Director: ed in by the	Certification:	4 ☐ Homicide determined	building, etc	. (Specify)				City or Tow			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Schneletely filled in by the fune	Medical	29a. Certifier 1 ♣ Certifying Pl (Check only one) 2 ■ Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination ar	e, deat nd/or in	n occurred at the time vestigation, in my opi	e, date and place, inion, death occu	and due to the or rred at the time, o	ause(s) and ma date and place, a	nner as s and due t	stated. to the cause(s)
	To the Twithin 2	M	29b. Signature and title of certifier		11-7		29c. License	62141		29d. Date signed August 2	21 '	2007
	A Company		30. Name and address of person who	completed cause of de	eath (Item 23a) 1221	(Type,	Print) ERCANTILE	= LANE	LARGO	ns 2	0774	t (KAISER
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	1						
	Registi	ar	AUG 2 2 20	Ul Been	· B.	Ope						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2007 28379 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Avaust 5:39 PM 17 2007 Johnson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Northwest Hospital Randallstown Baltimore Center If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Jan 29 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Year) 1927 **Funeral** 1 ☐ XM 2 ☐ F Jan. 80 Maryland 214-20-3436 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a State 10h County r then "naturel", or iteme 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Baltimore MD Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 3526 Rolling Road 21244 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1XXVes 2 □ No 1944 – If Yes, Give 1946 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: Specify: White 1946 Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Woodlawn Motor Coach Bus Driver permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygier Important: if Item 27 ie marked other th. any njury or other traumatic event, I'm 2005. 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Driver Philip Johnson Lottie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21244 3526 Rolling Road Vivian L. Johnson Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn, MD Aug. 21, 2007 Woodlawn Cemetery 4 ☐ Sonation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Burrier-Queen Funeral Home & Crematory, PA
1212 W. Old Liberty Road Winfield, MD 21784 21. Sign of Funeral Service Licensee Approximate Interval Between Onset and Death Part. Enter the disease, or complications that caused the slock, or hend failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immedia e Cause Final disease condition resulting in Jeath) Myocardia Infarction acute Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of) Examiner To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ #fiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 TR/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 4 hours after dec-1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 | Homicide 12 Certifying Physician: To the best of my knowledge ideath occurred at the time, date and place, and due to the causa(s) and manner as stated. 29a. Certifier Medical (Chack only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MHaron M) D56418 August 17 2007 FIVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old Court Road, Randallstown, MD 21133 K. Tonya Mason, MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State AUG 2 0 2007 Registrar

DHMH 17 Rev 1/2001

	1	For State Registrar	State of Maryland	Cei	artmer <i>tificat</i>	e of E	eath	vientai ny	/gierie Reg. No	2007	28380
nysician Medical	3	Decedent's Name (First, Middle, Las Beatrice L. Johns	•					2. Date of D Month August	eath 16,	^y 2007 ^{Year}	3. Time of Death 11:30 AM
xaminer	4	a. Fecility Name (If not institution, give Larkin Chase Nurs				Bowie		1		Prince (	George's
neral ector		78-32-0348	9x	birthday) Yrs.	If Unde Months	n 1 Year Days	Hours Min.	8. Date of B (Month, D June 4	av Yaarl	9. Birth	nplace (State or Foreign untry) shington, D
e nutified at	1	Jsual Residence of Decedent  Oa. State 10b. County  Acceptable 10b. Paring on	George's M	own or Lo		110		<u> </u>			10d. Inside City Limits
drar cost by notified Funeral Director	1	Maryland   Prince Oe. Street and Number  14020 Mount Oak (	<u> </u>	ITCCII	10f. Zij					izen of What Co ted Stat	*
	1	1. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:			dent of His	panic Origin? (S , Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	0-	14. Race - Amer Black, White Specify:	
t, the Madest Exp Completed by	_	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12 years	ucation	(Give lite. l	kind of wo	al Occupa ork done do se retired)	uring most of wor	king		overnmer	•
atic event, the To Be Co		7. Father's Name (First, Middle, Last)  John Lewis		OTE	LICAI		18. Mother's Nan	ne (First, Middle ce Carp	e, Maiden	Sumame)	L to
r traumati		19a. Informant's Name/Relationship (1		19b. Mailir 1402	ng Address	s (Street a	nd Number or Ru	ral Route Num. itchell	ber, City o	or Town, State, Z e, MD 20	(ip Code) 0721
any injury or other traumatic event, the Magnes.  To Be Compl		20a. Method of Disposition  1 ☐ Burial 2元 Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Uicen	Removal from State Lee	s Cr	emato emato !. Name a	other place OTY nd Address		ewart I	07 uner		, MD
for use as the burial-transit aurillor use as the burial-transit aurillor use as the burial-transit aurillor use as the burial-transit aurillor use as the burial-transit aurillor use as the burial-transit aurillor use as the burial-transit aurillor use as the burial-transit aurillor use as the burial-transit aurillor use as the burial-transit aurillor use as the burial-transit aurillor use as the burial-transit aurillor use as the burial-transit aurillor use as the burial-transit aurillor use as the burial-transit aurillor use as the burial-transit aurillor use as the burial-transit aurillor use as the burial-transit aurillor use as the burial-transit aurillor use as the burial-transit aurillor use as the burial-transit aurillor use as the burial-transit aurillor use are the burial-transit aurillor use and the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the burial-transit aurillor use are the		23a. Part1. Enterthe disease, or compositions controlled the cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Respiratory  a. Due to (or as a consequer  Due to (or as a consequer  Due to (or as a consequer  Due to (or as a consequer  C. Due to (or as a consequer  d.	Failu		de of dying	, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
etached for use at Physician/Me		FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☆ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	ath 3	Ectopic p Other (s					23d. Date of deli Month	very Day Year
<b>a</b> 8		Part II. Dther significent conditions of General Debility	ontributing to death but not resulti	ng in the u	nderlying	cause give	n in Part I.				the cause of death?
page 2 should I	-							per	s an opsy formed?	prior to death?	topsy findings available completion of cause of 2 \square No
Be	2	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only	one)		
2 0		1 Yes 2X No	Hospital: 1 ☐ Inpatient 2 ☐ EF				463 Nuising n			6 □Other (Spec	cify)
by the funer rtification	2	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year)	Bb. Time of Injury e, farm, str	М		at ? es 2 □ No	28f. Location City or To		nd Number or Ru	nal Route Number,
completely filled in by the			ysicien: To the best of my knowled iner: On the basis of examination and manner stated.								
comple		29b. Signature and title of certifier	my n	40		c. License				te signed (Monti	
		30. Name and address of ne on who	co eted cause of death (Item 2	3a) (Type.	Print)						

DHMH 17 Rev 1/2001

ORIGINAL

Marvin Eugene James 07-06227 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK UNK State of Maryland / Department of Health and Mental Hygiene 2007 28381 1- For State Certificate of Death Rea. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day August 13, 2007 0207 hrs Medical Examiner E. James Marvin 4c. County of Death 4a, Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Beltsville Prince George's Edmonston at Sunnyside 8. Date of Birth (MM/DDAY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year I If Under 24Hrs Funeral 7. Age (In yrs. last birthday) oreign Washingtor Months Hours November 7, Director 579-17-5836 17 1 X M 2 F Yrs Usual Residence of Deceden 10a, State 10d. Inside City Limits 10c. City, Town or Location Washington, DC DC 1 X Yes 2 No 28a-f show notified at once. with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 20011 4108 5th St. NW USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must be r 1 X Never Married 2 Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Married Yes 9 Specify: Black hours after Give Year 4 Divorced Yes 2X No specify: marked other than "natural", c event, the Medical Examiner ģ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) permit, Pages 1 and 2 should be filed within 72 P Department of Health and Mental Hygiene Important: If item 27 is marked other than "n injury or other traumatic event, the Medical E Elementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 none 11th none 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Marvin Dixon Angela James 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State; Zip Code) 4108 5th St. NW, Washington, DC 20011 Angela James / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Harmony Memorial Park 08/20/2007 | Landover, Maryland Donation 5 Other Specify: 22. Name and Address of Facility Johnson & Jenkins Funeral Home . Manature of Funeral Service Licensee 716 Kennedy St. NW, Washington, DC 20011 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED signed by the attending physician be detached for use as the burial AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed Division of Vital Records, certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) funeral director. æ examiner? Hospital: 1 Other: Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene After this ۵ 1 🗸 Yes 28a. Date of Injury (Month, Day Year) Aug 13, 2007 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Driver auto auto collision within 24 hours after death.

To the Funeral Director: A completely filled in by the fun 1 Natural 0206 hrs Yes 2 🗸 No Pending 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Edmonston at Sunnyside, Beltsville, MD determined (Specify) Major Road / Highway Homicid 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner

29b. Signature and title of certifier

and manner stated

32. Registrar's Signature

State Registrar 29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 13, 2007

07-06462 Soo Nam Kim Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

oo nam niii		For State  Registrar	Certif	icate of		u Mentai		g. No. 201	07 2838
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last)  Soo Nam Kim			_		2. Date of Deat Month August 21	h Day Year , 2007	3. Time of Death 0302 hrs
he has		4a. Facility Name (If not institution, give street 3005 Bethany Lane	and number)	41	c. City, Town, or Ellicott City			4c. County of Deat	h
Funeral Director			7. Age (In yrs. last	birthday) Yrs.	If Under 1 Yea Months Day		8. Date of Bird fin. 09/20/	1922 C.	rthplace (State or gn DuntryS. Korea
any.		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Locatio	n				10d. Inside City Limits
daryland 28a-f show 1 at once.	ē	MD Howard	Elli	cott (	10f. Zip Code		1 1 1 1	og. Citizen of What Cou	1 Yes 2 XNo
ith the Mar. 23a or 28a	Director	3005 Bethany Lane			21042		"	Korea	anu y :
eath with items 23 ust be no	Funeral		as Decedent Ever in U.S. med Forces?  Yes 2 X No		Decedent of His s, specify Cubar		Specify Yes or No- erto Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
safter d	≩.	3 X Widowed 4 Divorced If Yes, or Date	Give Yeer		Yes 2X No		of words done	Specify: AS13	
5 72 hour in "natu	Completed		liege (1-4 or 5+)	during mo	st of working life				·
-0036 4 within 72 giene. ther than '	ошо	0 17. Father's Name (First, Middle, Last)		Homema	ker	18.Mother's Na	ime (First, Middle, M	Own Home	
21215-0036 uldibe filed within 7 Mental Hygiene. marked other than c event, the Medica	a		Unknown					Unknow	
e, MD 2. I and 2 should Health and M item 27 is m	٩	19a. Informant's Name/Relationship (Type, Pr Chang Soo Lee/son	nt )				or Rural Route Num Ellicott (	nber, City or Town, Stat City, MD	e, Zip Code) 21042
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mointal Hygiene. Ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition  1 Burial 2 X Cremation 3 Rer	noval from State cres	ce of Disposit matory or other			Date 21/2007	20c. Location - City of Catonsvi	
Baltimore, permit. Pages I and Department of Heal Important: If iter	1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	M01442	22. Na	ame and Addres	s of Facility Ha	rry H. W	itzke's Far	nily FH Inc.
Physician		23a. Pert I. Enter the disease, or complication failure. List only one cause on each line.	s that caused the death. Do	1411	2 Old C	olumbia	Pk El	licott City	Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease a. Hype	tensive Atherosclero (or as a consequence of):	otic Cardio	ovascular Di	sease			Death
	<u>آ</u>		(or as a consequence of):						
ed nsit	Examiner	events resulting in death) Last	(or as a consequence of):						
e execut cian and rial - tra	Medical	UNPENDED d.	NDED						
Division of Vital Records, P.O. Box 68760, To the Itospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 ✓ No 9 Unknown g	If yes, outcome of pregnar Live birth Pregnant at time of death Unknown	2 Feta	al death 3 er (Specify)	Ectopic pre	gnancy	23d. Date of delive Month	ry Day Year
P.O. Es that the d	2	Part II. Other significant conditions contrib	outing to death but not resu	ilting in the ur	nderlying cause	given in Part I.		obacco use contribute to	o the cause of death?
Division of Vital Records, P.O. tal or steading Physician: The law requires that it is after death.  al Director: After this certificate has been signed by led in by the fumeral director, page 2 should be detach	Completed							prior to rmed? prior to death?	utopsy findings available completion of cause of
ital Rec ician: The sertificate	Be C	25. Was case referred to medical examiner?			26.Plac	e of Death (Che	eck only one)		kammal
n of Vit ding Physic a. After this funeral dire	의	1 V Yes 2 No  27. Manner of Death  1 V Noture	impatient 2 Er	R/Outpatient Bb. Time of In	ijury 28c. Inju	ıry at Work?	rsing Home 5 28d. Describe	Residence 6 Oth	er: Scene
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be	ie. Place of Injury - At home	e, farm, stree		Yes 2 No building, etc.	28f, Location (S or Town, S		tural Route Number, City
Di To the Hospital of within 24 hours a To the Funeral I		4 Homicide	specify) the best of my knowledge,						
To the within 2 To the complet	Medical	and m  29b. Signature and title of certifier	anner stated.		29c. Licen	se number		29d. Date signed (M	
		Theoder M.	Fry Me	ws	0.0	M.E. 0	CME	August 21, 200	7
Oa	Ų.	9.	ssistant Medical Exa		111 Penn Si	reet, Baltim	ore, MD 2120	1	
St Regist	ate rar	31. Date filed (Month, Day Year) AUG 2 2 2007	32. Resistrar's Signature	x do	and I				-

			For State Registrar	State of Maryla		artment of I rtificate of		, ,	giene Reg. No. 200	7 28383
	Physici	an	1. Decedent's Name (First, Middle, Last					Date of Dea     Month	Day Yea	3. Time of Death
-	/Medic	al	MICHAEL LEE  4a. Facility Name (If not institution, give	KIDWELL		4h City Town	or Location of Death		18, 2007 4c. County of De	4:20 a M
	Examin	er	9528 48th Place	street and number)			e Park	•	,	George's
- 100 × 20	Funeral		5. Social Security Number 6. Se	3 1 7	s. last birthday)		If Under 24 Hrs.	8. Date of Birtl	n 9.8	irthplace (State or Foreign Country)
,44	Director		216-40-7800 Usual Residence of Decedent	XIM 2□F 65	Yrs.			01-05-		ryland
	rland ow		10a. State 10b. County	10c. 0	City, Town or Lo	ocation				10d. Inside City Limits
	a-f sh	ctor	Maryland Prince G	eorge's Co	ollege 1	Park				1 XYes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	s 23a	Funeral Director	9528 48th Place	12, Was Decedent Ever in	118 12	20740		necify Ves or No-	U.S.A.	nerican Indian,
"	r item	Fun	11. Marital Status 1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 ∐Yes 2 X No			Hispanic Origin? (Si pan, Mexican, Puert	o Rican, etc.)	Black, WI	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: W	hite
5-0	"natu	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occu kind of work done	pation during most of wor ed)	king	16b. Kind of Busines	s/Industry
12	withir lene. • than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+) 2+		actor	·u/		Own Busi	ness
	e filed al Hyg other vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Surname)	
ylaı	ould b Menta arked	10	Robert Howarth K					ouise Wa		
Maryland	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (7)  Janet Eileen Kidv	,		-			er, City or Town, State	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	20b	. Place of Dispo	osition (Name of matory or other pla	1	Date Pa.	rk, Maryla 20c. Location - City	
E E	Page: nent o int; If i		1 ☐ Burial 2 🕅 Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State  ) Me	-	an Cremato	· i	24-2007	Alexandri	a, Virginia
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per dwr. 22 per ab 9871 9-13-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Katherine Ida Larmore Augus /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner AMBKIDGE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Funeral 1 ☐ M 2 🔭 F 99 551-48-1315 9/12/1907 Director Oregon Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Dorchester Cambridge 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 21613 USA 1721 Brannocks Neck Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: g white 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Doratha (unknown) James Clemmons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mardela Springs, MD 21837 311 Bridge St., James W. Larmore/son 20b. Place of Disposition (Name of cemetery, crematory or other place)
State of Maryland
Anatomy Board 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/21/07 Baltimore, MD 4x Donation 5 ☐ Other (Specify) State Aretony Hoard 655 W. Balton S. Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir shock, or heart failure. List only one cause on each line. Ronald S. Wade isbury, Immediate Cause (Final disease or condition resulting in death) Physician Memio /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical ase 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 ☐ Yes 2 No 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 2 ☐ Accident funeral 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number D0661877 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier n who completed cause of death (Item 23a) (Type, Print) Byrn St, Cambridge, 30. Name and address of admater cJ.W 32 Registrar's Signature State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 28385

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** -OPZZ aura 0210 M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coastal Hospice at the Lake Salisbury Wicomico If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 😿 F 133-48-4869 Director 6/18/1956 New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits iral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Wicomico Eden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5071 Cooper Landing Drive 21822 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ☐Yes 2 No Yes, Give 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: þ Specify: 3 Widowed 4 Divorced white "natural", Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Manager Dunkin Doughnuts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nunzio Zaccheo Faye Iaquinto ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Felix Lopez/husband 5071 Cooper Landing Dr., Eden, MD 21822 of Health Item 27 I 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Allen Cemetery 8/18/07 Allen, MD 21. Signature of Funeral Service Ligensee Association Professional Association Kell K 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Netostatic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed led by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 DEctopic pregnancy Day Month Year 4□Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗆 🕅 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 7 24a. Was an has autopsy performe Yes To the Hospital or American within 24 hours after death.

To the Funeral Director: After this certifical that the Funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only onle Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 27 No 1 Impatient 2 2 ER/Outpatient 3□ DOA 27. Manner of leath Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner sta 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Box 1733 Solis 4, MD 2180aun 4 State Registrar

DHMH 17 Rev 1/2001

			State State amended item #2	of Maryland / 6/wico/map/	Depa Cer	rtment of H tificate of L	ealth and Death	Mental Hy	giene Reg. No. 2	307	28386
Н	3 36 1		1. Decedent's Name (First, Middle, Last)					2. Date of De		Year	3. Time of Death
	Physici /Medic	_	HAROLD LEER	oy LAU	LER			08	15	2007	7:13 PM
,	Examin		4a. Facility Name (If not institution, give street and	number)		4b. City, Town, or		ith		ty of Death	4.60
			28979 Log Cabin Road  5. Social Security Number 6. Sex	7. Age (In yrs. last b	hirthday)	SALIS If Under 1 Year	BURY If Under 24 Hr	S 8 Date of Bir		1COp	Nace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1 3 M 2 □		Yrs.	Months Days	Hours Mir		iy, Year) <b>949</b>	Cour	sylvania
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	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Mec	, and			29c. Licens	e number		29d. Date sig	ned (Month,	Day, Year)
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7	311		30. Name and address of person who completed	cause of death (Item 23	a) (Type,	Print)					
	V		6HUMM WARIS CO	ASTAL HO	SPIC	R P.	BOX 17	33 , SA	LISBU	Mu	0 21802
Q.	Sta Regist	ate	30. Name and address of person who completed  GHUHN WAR (\$ CO  31. Date filed (Month, Day, Year)  AUG 9 2 2007	32. Redistrar's Signature	4	boards )					
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			1 - State Registrar			rtificate of Death	Re	J UU J	28387
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_			Garrett County		Spital ge (In yrs. last birthday)	Oakland If Under 1 Year   If Under 24 Hrs.	8 Date of Birth	Garrett	nplace (State or Foreign
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other treumatic event, It a Medical Exertinating at ance.	Completed	15. Decedent' (Specify only highest	grade completed)	16a. Dece (Give life.	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king	6b. Kind of Business/	
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on of	iding Ph th. : After th funeral		27. Manner of D ath  1 Natural 5 ☐ Pending	28a. Date of Inj. (Month, Da	ury 28b. Time o	- Introduction	28d. Describe hov		
Division	l or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not determine	and 286. Place of in	jury - At home, farm, str tc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th compietely filled in by the funeral	Medical C	29a. Certifier (Check only one)  Certifying	Physician: To the best exeminer: On the basis of and manner si	of examination and/or in	h occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	ro the vithin of the omple	Me	29b. Signature and title of certifier			29c. License number	29	d. Date signed (Month	n, Day, Year)
	->-o		> May anxos	1 a Klein	n An	Deldaso	8	-24-2m	フ
		5	30. Name and address of person w	no completed cause of	death (Item 23a) (Type,	Print)	0.1.0.	d	215-5
•	Sta	ite	31. Date filed (Month, Day, Year)	32. Regist	rars Signature	yanta nyuway	vances	and , sed	21300
	Regist	rar	AUG	2 8 2007	March St.	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 28388 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Esther Mae Liles 2007 August 16 6:48 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Hospital Cheverly Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sey 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🔀 F 579-34-0286 79 June 20, 1928 Ayden, **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Examiner πust be notified at 1√2Yes 2 No Director D. C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20019 3938 Blaine Street, NE United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner ⊡ust by Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: Black 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearlie Blount Joe Jackson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest Jackson/Brother 5707 Ramblewood Avenue, Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial 8/24/07 Landover, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Pope Funeral Hores, 21. Signature of Funeral Service icensee 5538 Marlboro pike, Forestville, Md. 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 10-20 MINS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of). Examine The law requires that the death certificate be executed burial-trar physician pidemi Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Dav Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed?

1 Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

To the Hosp within 24 hor To the Fune 2 State

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) Registrar

(Check only one)

29b. Signature and title of certifier

DAMUEL

mue

32. Registrar's Signature

3001

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALLEYNE

DHMH 17 Rev 1/2001

29c. License number

25766

29d. Date signed (Month, Day, Year)

CHEVERLY, MD 20785

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Directo

Funeral

Completed by

Be ၉

**Funeral** 

Director

permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if flem 27 is marked other than "natural!" or itemated.

The law requires that the death certificate be executed burial-trar and attending physician for use as the þ signed t page 2 should peen certificate has Physician: funeral director, After this or Attending within 24 hours after death To the Funeral Director: filled in by

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical Completed by Be Medical Certification: To

IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other:  $4\square$  Nursing Home  $5\square$  Residence 6 Kother (Specify) Living 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No

Manner of Death
Natural
Control
Accident

3 Suicide 4 Homicide

6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) August 20, 2007

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my existing death occurred. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14999 Health Ctr. Dr.

Bowie, MD.

Kelvin B. Hao, M.D. 31. Date filed (Month, Day, Year)

AUG 2 1 2007

32. Registrar's Signature D. Speck

3

State

Registrar

Hospital

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

,		1- For State Certificate of L		Reg. No.	2007 2839			
Physicia	an/	Decedent's Name (First, Middle,Last)		Date of Death Month Day	3. Time of Death Year 1530 hrs			
ledical Exami	ner	Raymond Edward Lee  4a. Facility Name (if not institution, give street and number)  4b.	City, Town, or Location of Death	August 13, 2007				
			Clinton	4c. County of Death Prince George's				
Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplai						
Director								
any		10a. State 10b. County 10c. City, Town or Location		i	10d. Inside City Limits			
<u>*</u> , , ,	_	Md. Prince George Forestvil	1e	11 1.5	1 X Yes 2 No			
faryla 28a-f l at or	Director		Of. Zip Code	10g. Citizen	of What Country?			
the N 3a or otified		3737 Donnell Drive- Apt 302	20747	USA				
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene ten 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	Funeral		Decedent of Hispanic Origin? (Spec , specify Cuban, Mexican, Puerto Ri		Race - American Indian, Black, White, etc.			
after	by F	3 Widowed 4 Divorced of Yes, Give Year 1 Y	es 2 X No specify:		ecify: Black			
hours natur Exam		during most	Usual Occupation (Give kind of work tof working life DO NOT use retired		of Business/Industry			
36 pin 72 s. than "	ompleted	College (1-4 or 5+)   Truck	Driver	Roh	Hall			
d with	Com	17. Father's Name (First, Middle, Last)		First, Middle, Maiden Sun				
21215-0036 Uld be filed within 72 hours a Mental Hygiene marked other than "natura c event, the Medical Exami	Be	Joseph Colbert	Beverly	Lee				
21 hould nd Me is ma			ddress (Street and Number or Ru		- 1			
MD and 2 sho salth and 27 is raumat	-	David Lee 2763  20a. Method of Disposition 20b. Place of Disposition	Pinewood Drive	e, Waldorf. Date   20c. Loca	, Md. 20601 ation - City or Town, State			
Baltimore, MD 21215-00. permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other ti injury or other traumatic event, the Mec		1 X Burial 2 Cremation 3 Removal from State crematory or other	r place)		,			
t. Pag tment tment:		4 Donation 5 Other Specify: St. Thomas			den, Maryland			
Bal permi Depar Impo injur		21. Signature of Funeral Service Licensee 22 Nag 20	ne and Address of Facility ams Funeral Ho 605 Aquasco Ro	ome,PA oad,Aquaso	co,Md.			
Physician	Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart							
Medical. Examiner	Immediate Cause (Final disease a. Torso Injuries							
		or condition resulting in death)  Due to (or as a consequence of):						
	Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	aminer	cause. Enter Underlying Cause (unsease or mjury that imitaled  purpose require in death). Lest  Due to (or as a consequence of):						
ruted nd ransit	Exa	events resulting in death) Last Due to (or as a consequence of):  d.						
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED						
760, icate bo		IF FEMALE: 23c. If yes, outcome of pregnancy			ate of delivery			
Sox 68' death certifi e attending for use as 1	/sician/	past 12 months?	death 3 Ectopic pregnand	cy Mo	onth Day Year			
Box 68' e death certifi the attending	ysic	1 Yes 2 No 9 Unknown g Unknown	r (Specify)					
P.O. Ess that the digned by the	y Phy	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.		contribute to the cause of death?			
ords, P.O.  requires that the the the the signed by the should be detached.	ed by				o 3 Probably 4 Unknown			
ords w requi s been should	plete			autopsy	24b. Were autopsy findings available prior to completion of cause of			
tal Reco	Completed			performed? 1 ✓ Yes 2 No	death? 1 ✔ Yes 2 No			
Vital Rec ysician: The his certificate	Be C	25. Was case referred to medical examiner?	26.Place of Death (Check on	nly one)				
Physic r this all dire	2	1 Yes 2 No Inpatient 2 V ER/Outpatient		Home 5 Residence				
Division of Vital Records, tal or Attending Physician: The law requires after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should.	ertification:	27. Manner of Death  1 Natural 5 Pending 2 ✓ Accident Investigation  28a. Date of Injury (Month, Dev Year)  Aug 13, 2007  28b. Time of Injury (Month, Dev Year)  1357 hrs		28d. Describe how injury of perator of motorcy	vole involved in auto accident			
IVIS or At after d Direc	tific	3 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street,		or Town, State)	Number or Rural Route Number, City			
D spital hours	Ç	4 Homicide determined (Specify) Major Road / Highway	Highway N/B 301 Crain Hwy @ Missouri Avenue, Upper Marlboro,					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurre and one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.						
F × F ð	Ř	29b. Signature and title of certifier	29c. License number		e signed (Month, Day, Year)			
		Muna Pranell, MD	O.C.M.E.	Augus	t 14, 2007			
SB		30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 111 Pe	nn Street, Baltimore, MD 2	1201				
St Regist	ate	31. Date filed (Month, Apy Year) 2 200 732. Resistrar's Signature	rele					
regis	1							

DHMH 17 Rev 1/2001 OCME 2006

OCME

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. Ne. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:14 P NORMA **EVANS** MARSHALL 18, 2007 August /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 3003 Union Church Road Tylerton Somerset 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 9, 1925 9. Birthplace (State or Foreign **Funeral** Days Mary Land Months Hours 1 □ M 2 □ F 82 Yrs. Director 212-40-9389 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show the Mudical Examinator must be notified at 1 ☐ Yes 2 No Director Maryland Somerset Tylerton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 3003 Union Church Road U.S.A. 21866 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other then "netural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ð Specify:White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Merrill Tyler Myrtie Evans 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina Evans Corbin (Daughter) P. O. Box 234 - Tylerton, MD other 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 5 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Calvary Church Cemetery 8/23/07 5 Other (Specify) Rhodes Point, MD 4 Donation 21. Signature Funera Service los s Robert H. Bradshaw, Jr. 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St.- Crisfield, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVD Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Box 68760. physician by Physician/Medicai the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy performed certificate 2 No 1 ☐ Yes Hospitel or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 0 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After ' 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by after 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 D 48098 6, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD 21817 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 22 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:00AM Paul William Marshall 8/17/07 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** KENT Heron Point Chestertown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/1/1920 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 ★M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 178-03-4672 86 PA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or rother traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits X_{□Yes 2□No} Chestertown MD Kent Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code IISA 141 Campus Ave Heron Point 21620 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (25)Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes Ž☐ No Specify Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Die Casting Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Valenteen Paul Marshall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sudbury, MA 01776 Paul Marshall/Son 74 Puritan Ln. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State St. Paul's Cemetery 8/25/07 Chestertown, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Kuks 130 Speer Rd. Chestertown, MD 21620 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or com shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of): Stoge A Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760 Physician/Medical as t signed by the attending of the detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No law 24a. Was an has t autopsy page certificate 1 Yes 2 1√0 or Attending Physician: 25. Was case referred to medical director 26. Place of Death (Check only one) Be examiner' Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA ۵ After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) Injury 5 | Pending To the Hospital or Attendinwithin 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 □ Yes 2 □ No 2 Accident investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner equated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

LP

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year AUG 2 1 2007

30. Name and address of person who completed

to non w

of death (Item 23a) (Type Print) AD STES CHESTERTOWN, My 2003 32. Registrar's Signature

00060301

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Grace W. Murphy 18 2007 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death County of De a Pla Charles Medica enter If Under 1 Year 9. Birthplace (State or Foreign Country) Washington DC If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Days Hours 1 ☐ M 2 💢 F 579-18-7498 86 1921 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes X☐ No Waldorf Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2554 Husk Place, Apt. 101 20602 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leonard G. Helwig Annie I. Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 41 Pagnell Circle, Waldorf, MD 20602 Dorothy Townsend -20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial Gdns; 8-22-2007 Waldorf, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3035 Old Washington Road M01246 Waldorf, MD 20601 Huntt Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1WDROME IGIPONIZO DURNOWD disease or condition resulting in death) Due to (or as a consequence of) 165 PERMITORN Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 1☐Live birth 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

**Physician** /Medical Examiner Examine

burial-trar

as the attending I

signed by the a

page 2 s

To the Hospital or Auconation within 24 hours after death.

To the Funeral Director: After this certificate has remoletely filled in by the funeral director, page?

Physician/Medical

Be

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Certification:

Medical

physician

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

**Physician** 

Examiner

**Funeral** 

Director

show

Directo

Funeral

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Completed

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ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

12 should be filed w h and Mental Hygie 7 **is marked other ti** 

Injury or other traumatic event,

permit. Pages 1 and 2 a Department of Health at Important: If item 27 is any Injury or other trau once.

with the Maryland

/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IE	FEMAL	E.

23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Completed by 25. Was case referred to medical examiner? 1 ☐ Yes 2 No

27. Manner of Death

1 Natural
2 Accident

3□ Suicide

4 ☐ Homicide

determined

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signar and title of certifier

29d. Date signed (Month, Qay, Year)

and address of of death (Item 23a) (Type, Print) NATINEW MO.

WALDORK, MI 31. Date filed (Month, 32. Registrar's Signature 20d7

State Registrar

MP2

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Mary H. Mercer 2007 7:15 August 16 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1204 Southwind Court Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months 1 ☐ M 2 ☑ F 89 14, 166-18-5968 1918 Pennsylvania Jan. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be added. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Anne Arundel Maryland Annapolis 1 ☐ Yes 2XXNo Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 1204 Southwind Court 21403 U.S.A. Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ŽŒNo Specify: Specify: White þ 3XXVidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (unknown) Sarah Munley P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Leslie Morgan/daughter 1204 Southwind Court Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 8/21/2007 | Annapolis, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signatur Imeral S rviv Licens 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) erelovovasculan disease - mos. **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any parting to firm data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy nerforn 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification:

The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760. cate has been signed by the a page 2 should be detached To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

(Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

ddress of person who completed cause of death (Item 23a) (Type, Print) + E. Selonick, MD 900 Bestgate Rd. Annapolis, Md. 21401

State Registrar

Medical

that the death certificate be executed Box 68760. P.O. Division or Vital Records, The law requires

Baltimore, Maryland 21215-0036

and -tran the certificate Hospital or Attending Director: within 24 hours a To the Funeral C

> 10 State Registrar

Medical

31. Date filed (Month, Day, Year)  $\begin{array}{c} \text{AUG 2 2} \end{array}$ 

6 Could not be

determined

Shalle, m

3 Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifier



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

000048050

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

3/22/07

Ralph William McKay
1- For State

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 28396

Reg. No.  Physician/  1. Decedent's Name (First, Middle,Last)  2. Date of Death								3. Time of Death		
Modical Examin	er	Ralph William McKay, Jr.  Month August 1:						7, 2007 Year 0620 hrs		
<b>.</b>		4a. Facility Name (if not institution, give 7700 Landover Road	street and number	')	4	b. City, Town, or L Landover	ocation of Deat	h	4c. County of De Prince Geo	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday			•	Months Days Hours Min			Birth(MM/DD/YYYY) 9. Birthplace (State or 9/05/1984 Foreign Country) MD	
Director	-	Usual Residence of Decedent	M 2 F	·	22 Yrs.			09/	03/1304	Country) MD
v any	Γ	10a. State 10b. County		10c. City, T	own or Location	on				10d. Inside City Limits
Maryland 28a-f show any d at once.	اِق	MD Prince (	Georges		Largo		- ,			1 X Yes 2 No
or 28a	Director	10e. Street and Number         10f. Zip Code           10911 Dubs Court         20774				774	10g. Citizen of What Country?  USA			
with the ns 23a	ᇹ	11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin				anic Origin? ( S			merican Indian, Black,	
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nrs afte	ᆰ	3 Widowed 4 Divorced  15. Decedent's Education (Specify only	If Yes, Give Year or Dates: v highest grade co	mpleted) 1		Yes 2 X No		wórk done	Specify: 16b. Kind of Busine	Black
72 hou	뺭	Elementary/Secondary (0-12)	College (1-4 or			st of working life. I				
0036 within iene.	Completed		2		Autor	notive Te			Automob	ile ·
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner, must be notified at once.	B B	17. Father's Name (First, Middle, Last) Ralph William Mc	Kay, Sr.				8.Mother's Nam Magalei		Maiden Surname)	
212 lould bould by Ment s mark tic ever		19a. Informant's Name/Relationship (Ty	pe, Print)			Address (Street	and Number or	Rural Route Nur	mber, City or Town, S	tate, Zip Code)
MD and 2 sho alth and im 27 is raumati		Magalene McKay/m  20a. Method of Disposition	other	I son Di		Dubs Cou			20774	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation 3	Removal from S	tate cre	ematory or oth	er place)		Date	20c. Location - City	
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Ba Perm Dep Imp		Dory Montgomery	· Cheat	Rain-					entwood, M	
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		Sequentially list conditions, b								
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
ted Insit	EXal	events resulting in death) Last  Due to (or as a consequence of):  d.								
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Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1										
To t To t com	Medical		and manner stated			29c. License			29d. Date signed	
(10)		anetz				O.C.N	И.E.		August 17, 20	007
Olive		30. Name and address of person who c			,	troot Dalii	n MD 040	04		
ا کاکر	ate		t Medical Exa	miner 1 rar's Signature		treet, Baltimo	re, MD 2120	J1		
Registr		31. Date filed (Month, Day, Year) AUG 2 1 2007 L		1	-					

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	Physici /Medic		Janet Marie Marshall		August	16 2007 2007	11:58 A™
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	*	* *	Southern Maryland Hospital	Clinton  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Prince G	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2X F 7. Age (In yrs. last birthda yrs.	Months Days Hours Min	(Month, Day, Mar. 21,	Year) Col 1954 Was	hplace (State or Foreign untry) Sh., D.C.
	aryland show d at	L.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
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	with the	盲	10c. Street and Number	10f. Zip Code 20772		USA	unity:
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or Vital	siciar certif rectol	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Hospital: 2 ☐ ER/Outpa	Other	ath (Check only on		-15.1
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Division	ospital or Attend hours after death. uneral Director: / ly filled in by the fi	Certification:	2  Accident investigation 3  Suicide 6  Could not be 4  Homicide determined 28e. Place of injury - At home, farm, building, etc. (Specify)	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	28f. Location (St. City or Town	reet and Number or Ru n, State)	ural Route Number,
ш	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, d  Medical Examiner: On the basis of examination and/o and manner stated.				
	To the Hwithin 24 To the Fu	Mec	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mont	
	(12)		I John R. Hokim, mo	04774	8	8/16/	2007
	Se		30. Name and address of person who completed cause of death (Item 23a) (Ty	D4774 De, Print) Domons Island Roc	ed, Hur	tingtown, u	u0 20639
	Sta Regist		31. Date filed (Month, Day, Year)  32. Registrar's Signature		,	<del></del>	- 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2:30 A 2007 Charles Moran August Joseph /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Queen Anne's Centreville 222 Concerto Ave. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 17, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours 1**™**M 2□ F Months 79 1928 Maryland 219-22-4624 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event: the Medical Economics. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 XYes 2 No Centreville Director Oueen Anne's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21617 222 Concerto Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:1945–65 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) IBM Corp. Management 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ola Rowzee Clarence Moran 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 Concerto Ave. Centreville, MD. Jacline P. Moran / spouse Baltimore. Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart Cemetery 08/21/2007 | Bowie, MD. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 20715 6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MELANOMA MONTHS **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transi Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ned by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, sign. þ 1 🗌 Yes 2510 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 1☐ Yes Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes မှ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Division Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 20 0

se TUA

State Registrar

2 1 2007 Sever 32.

Scott

EDEN, M.D., 2002 YVey 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

cal Phon

State 3 Registrar

ARASTOO

Date filed (Month, Day, Year)

YAZDAN]

32. Registrar's Signature

MD 9801 GEORGIA AVE, #3-41 SILVER SPRING MD 20902

**Physicia** /Medica Examine

> **Funeral** Director

1 - For State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit

Division or Vital Records, P.O. Box 68760,

1 - For State Registrar	Certificate of Death	Reg. No 2007 28400
1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year 3. Time of Death
Angela Christine McKendric	k	August 18, 2007 7 pm ^M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3806 Wine Rd.	Westminster	Carroll
5. Social Security Number 6. Sex 1	Months Davs Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Mar 27, 1987 MaryLand
217–27–8835 20  Usual Residence of Decedent		rat 27, 1987 Paryrana
10a. State 10b. County 10c. City	, Town or Location	10d. Inside City Limits
Maryland Carroll We	stminster	1 □Yes 2 ZÃÑNo
10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3806 Wine Rd.	21158	USA cify Yes or No. 14. Race - American Indian,
11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto F	
1 ☑Never Married 2 ☐ Married 1 ☐ Yes. 2 ☑No If Yes, Give Year or Dates:	1 ☐ Yes 2 🗷 No Specify:	Specify: White
15. Decedent's Education (Specify only highest grade completed)  Flomoston/(Specify only 1/2)  College (1.40r.5a)	16a. Decedent's Usual Occupation (Give kind of work done during most of workin	16b. Kind of Business/Industry
	`life. DO NOT use retired)	
11	Student 18 Mother's Name	School (First, Middle, Maiden Surname)
17. Father's Name (First, Middle, Last)		
2 Andrew McKendrick 19a, Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura	Fckhart I Route Number, City or Town, State, Zip Code)
1		ster, MD 21158
M/M Andrew McKendrick parents  20a. Method of Disposition 20b. P	ace of Disposition (Name of Disposition Page 1)	ate 20c. Location - City or Town, State
1 ☐ Burial 2 ☑Cremation 3 ☐ Removal from State	emetery, crematory or other place)	
4 □ Donation 5 □ Other (Specify)  21_Signature of Funeral Service Licensee	roll Cremation Inc 8/2	2/07 Hampstead, Maryland ts Funeral Home & Chapel, PA
Del VAL	412 Washington Rd. V	Westminster, MD 21157
23 Fart1. Enter the disease, or complications that caused the death	. Do not enter the mode of dying, such as cardiac o	r respiratory arrest, Approximate Interval Between
shock, or heart failure. List only one cause on each line. Immediate Cause (Final	1 in tout 1 =	disorder years.
disease or condition resulting in death)  Due to (or as a consequence)		mer ne C
Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ledder cf):	
Cause (Disease or injury that initiated events c.		
resulting in death) Last Due to (or as a consequ	uence of):	
and the control of immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C		
IE EENAN E.		
23b. Was decedent pregrant  1 Live birth 2 Feta	death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
The past 12 mounts?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	eath 5 Other (specify)	
Part II. Other significant conditions contributing to death but not resi	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
in a constant	er	1 ☐ Yes 2 █ No 3 ☐ Probably 4 ☐ Unknown
Secretary and the		24a. Was an autopsy findings available prior to completion of cause of
		performed?// death?
	26. Place of Death	1 Yes 2 No 1 Yes 2 No (Check only one)
examiner?	ER/Outpatient 3 DOA Other: 4 Nursing Hor	
27. Mann of Death 28a. Date of Injury (Month, Day Year)		28d. Describe how injury occurred
1 U atural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	M 1 Yes 2 No	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At hr building, etc. (Specif		28f. Location (Street and Number or Rural Route Number, City or Town, State)
27. Mann of Death 1 Unatural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 28a. Place of injury - At he building, etc. (Specification)  29a. Certifier (Check only one) 1 Certifying Physician: To the best of my known and manner stated.	wledge, death occurred at the time, date and place, a tion and/or investigation, in my opinion, death occurr	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Date/signed (Mgnth, Day, Year)
> Vincie L. Ryberg	D.O. H0061206	8/20/07.
30. Name and address of person who completed cause of death (Iten 4175-A Hanover Pik	23a) (Type, Print) Tracie L. Ryber	CQ D.O. 2/102
31. Date filed (Month, Day, Year) 32 Registrar's Signa	ture	
AUG 2 0 2007 Store &		

Stat Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** AUGUST 2007 Nicholas В. Merryman, III /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CECIL CECIL COUNTY UNION HOSPITAL OF ELKTON 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 **X**M 2 □ F 212-18-0404 Aug.7,1917 Baltimore, MD Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r 28a-f show notified at 1 Yes 2 □ No Director Chesapeake City Cecil 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a or Examiner must be 2 Shady Drive 21915 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married , or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white Specify: ģ 3 Widowed 4 Divorced 'natural", 1945 Completed 16a. Decedent's Usual Occupation Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene.

27 is marked other than "!
r traumatic event, the Med College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Agent Langner's 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nicholas Bosley Merryman Mary Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2 Shady Drive Chesapeake City, MD 21915 t of Health a Virginia T. Merryman (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or c 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 1 Other (Specify) Silverbrook Crematory 8/22/07 Wilmington, DE 21. Signature of Fun rai S rvio MCCrery Funeral Homes, Inc. 3924 Concord Pike Wilm., DE 19803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYOCARDIAL ACUTE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Just to for as a consequence of: Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 ☑ No 1∐ Yes this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of after death.

i Director: After the in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title D 63486 AUGUST, 11, 2007

State Registrar 30. Name and add

IIA.

HAMADEH 31. Date filed (Month, Day, Year) AUG 2 2 2007

Non who completed cause of death (Item 23a) (Type, Print) , ELKTON , MD 2192) 32. Registrar's Signature

		i	For State Registrar	State o	of Marylar		artment of F				giene Reg. No. 2	007	28402
	<i>%</i>	4	1. Decedent's Name (First, Middle,	Last)						2. Date of Dea			3. Time of Death
	Physicia /Medic		CHRISTINE	NKEIRU	MBONU					Month AUGUS	Day T 10.	2007	10;05a ^M
	Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, Town, or	Location	n of Death			unty of Death	
			NATIONAL INS	TITUTES	OF HE	АТТИ	BETHI	ESDA	(		MO	NTGOM	ERY
100	Funeral		NATIONAL INS 5. Social Security Number	6. Sex	OF HE 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		er 24 Hrs.	8. Date of Birt	1		place (State or Foreign
	Director		686-10-5746	1 □ M 2 🕱 F	51	Yrs.	Worters Days	Hours	MIII.	May 7,	1956	Nige	*/
	DC _		Usual Residence of Decedent		140 0								
	arylar show	_	10a. State 10b. County			ty, Town or Lo							10d. Inside City Limits
	Ba-f.s	cto	NC Wake		I	Raleigh	L						1 ∐Yes 21K No
	or 2	Director	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Cou	ntry?
	23a ust t		1512 Summervill					7610				geria	
	d within 72 hours after death with the Maryland giene. rr than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	11. Marital Status	Armed Fo	edent Ever in U prces?	I.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic C an, Mexic	Origin? (Spe an, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,	
Š	or h	by Fi	1 ☑ Never Married 2 ☐ Marrie	If Yes, Gi	ve	1	1 □ Yes 2 <b>I</b> No	Specif				ecify:	
5-0036	hour ural'		3 ☐ Widowed 4 ☐ Divorced	Year or D	ates:	10. 0						. B.	Lack
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7	withir ene. than	m	Elementary/Secondary (0-12) 12th	College (	1-4or 5+)		1 Market:				Salf	Emplo	oved
B			17. Father's Name (First, Middle, L	ast)		Recai	I Harket		her's Name	(First, Middle,			уса
a	be d o	Be	Stephen Mbonu						Joy Ol	,	maiden oun	name)	
≥	s 1 and 2 should f Health and Men Item 27 Is marke other traumatic	욘	19a. Informant's Name/Relationsh	in (Type Print)		19h Mailir	ng Address (Street				City or To	um Ctoto 7	- Code)
<u>B</u>	0 00 00		Henry Mbonu/br			1	Summervi						
a)	s 1 and 2 of Health Item 27 other tra		20a. Method of Disposition	other	20b.		sition (Name of matory or other place			Date		on - City or T	
פַ	Pages ment of I		1 ⊠Burial 2 ☐ Cremation		State			:e)				•	
saitimore,	it. P.	1	4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L		_   Fa	-	emetery	on of Eng	9-7-2			, Nige	ria
n n	permit. Pages Department of Important: If It any Injury or o		· Q. P. M	arsha	ell		Name and Address larshall 217 9th					DC 200	011
			23a. Party. Enter the disease, or shock, or heart failure. List of	complications that only one cause on a	caused the dea	th. Do not ent	er the mode of dyir	g, such a	as cardiac c	or respiratory ar	rest,		Approximate Interval Between
	Physician	i i	Immediate Cause (Final disease or condition	· Over	whel	mine	2002	2'5					Onset and Death
	/Medical		resulting in death)		(or as a consec		1						
	Examiner		Sequentially list conditions,	b. imm	JUNOSUN	012210	n for	95	aft	us. hos	it odi	2002	menting
	p #	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		(or as a consec			U					_
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Š	death certificate be executed e attending physician and d for use as the burial-transit		rosaling in death/ East	Due to	(or as a consec	querice of):	Stem cel	J	tren.	s plant	0		
۵/۵ ۵	ate b	dical		d									
0	ertific ling p e as	a l	IF FEMALE:	1									
X D D	w requires that the death certific been signed by the attending I should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live I	tcome pf pregn birth 2  Fet	al death 3 [	Ectopic pregnancy	,			23d.	Date of deliv Month	ery Day Year
- - -	the a	sic	1 ☐ Yes 2 Ø No 9 ☐ Unknown	4□Pregi 9□Unkn	nant at time of o	death 5	Other (specify)	-				MOILLI	Day Teal
7	The law requires that the tens been signed by the rage 2 should be detacher	된	Part II. Other significant conditio	no contributing to d	leath but not see	ultime in the co		:- D		OO- Dida			
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Records,	law las b	Completed	Renal FA	rilure						24a. Was		4b. Were auto	opsy findings available ompletion of cause of
=		5								perfo 1□ Yes	med?	death? 1 ☐ Yes	2.₽No
N I I S	Physician: r this certific ral director,	Be (	25. Was case referred to medical examiner?					26. Pla	ce of Death	Check onl o	ne		
5	<u>&gt; .</u> . ♥ 0	T ₀	1 ☐ Yes 2 No	Hospital: 1/X	Inpatient 2	ER/Outpatier	nt 3□ DOA Oth	er: 4 🗆 I	Nursing Ho	me 5 ☐ Resid	ence 6 🗆	Other (Speci	fy)
	ng ftel		27. Manner of Death  1/22(Natural 5 ☐ Pending	28a. Date (Mon	of Injury oth, Day Year)	28b. Time of Injury	f 28c. Injur Wor	y at k?	1	28d. Describe h	ow injury oc	curred	
<u> </u>	Attending r death. ector: After by the funer	atic	2 ☐ Accident investiga	ation				Yes 2[	□No				
UNISION	r Att	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned 28e. Place	of injury - At h	ome, farm, str	eet, factory, office		2	28f. Location (5 City or Tov	treet and Nu	umber or Rur	al Route Number,
	ital c irs af ral D	S			_								
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying 2 Medical E	Physician: To the examiner: On the band man	e best of my knoors basis of examination oner stated.	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	ne, date pinion, d	and place, leath occurr	and due to the red at the time,	cause(s) and date and pla	d manner as s ace, and due	stated. to the cause(s)
	withii To th	ž	29b. Signature and title of certifier	l			29c. Licens	e numbe	г		29d. Date sig	gned (Month,	Day, Year)
	(2)				× m	>	121	७१			8/	10/0	7.
Dis			30 Name and address of person v	vho completed caus			Print)	* .				-	
2)(			Daniel C	her to ul	O CENT	ER DR	IVE.BETE	HESD	A . M A	RYLANT	209	892	
	Sta		31. Date filed (Month, Day, Year)	32. F	Registrar's Sign	ature	, 1		**   ****		- 400	J.L.	
	Registr	ar	AUG 2 1 2007	beren	D. So	ule							

			For State Registrar	State of Marylan			nt of He te of D		Mental Hy	giene Reg. No.	2007	28403
	Physici /Medic		Decedent's Name (First, Middle, Las     Helen Caroline Ne	,					2. Date of De Month August	Day	y Year 2007	3. Time of Death 11:34 A M
É.	Examin Funeral Director	er	4a. Facility Name (If not institution, give 854 Cork Elm Courd 5. Social Security Number 6. S 1	t	last birthday) Yrs.		Severr	ocation of Death  If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 9/14/1	rth ay, Year)	County of Death  nne Arun  9. Birth  Cou	
	70	tor	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo Severn				7/14/1	<i>72</i> 1		10d. Inside City Limits 1 ☐ Yes 2☑ No
	th with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 854 Cork Elm Cour	-		10f. Z	p Code 21144				izen of What Cou	intry?
0500-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merfall Hylgiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at angle.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates:		Was Dec If Yes, sp 1 ☐ Yes		panic Origin? (S _I , Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	0-	14. Race - Ameri Black, White SpecifyWhit	, etc.
0-61717	i within 72 ho jiene. r than "natui th Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give life. I	dent's Us kind of w DO NOT emak		ion <i>ring m</i> ost of wor	king		ind of Business/Irwn Home	ndustry
/land /	uld be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last)  Carl Haug					18. Mother's Nam Cather	ne (First, Middle ine W.	, Maiden	Surname)	
, Mar	and 2 sho lealth and m 27 is me		19a. Informant's Name/Relationship (  Dean R. Nelson/so	on	854	Cork	Elm C	Court	Severn,	MD	or Town, State, Zi 21144	
baltimore	it. Pages 1 irtment of H rtant: If ite njury or otl		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifications)  21. Signature of Funeral Service Licer	st.	Place of Dispondentery, creating John	s Cea	metery	8/23		Elli	cott Cit	
D D	Depar Impol any Ir		23a. Part1. Enter the disease, or com	Vedde	41	12 0	ld Col	lumbia P	k. Ell	icot	t City,	MD 21043 Approximate
ř.	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Alzheimer Due to (or as a consect	s Deme							Interval Between Onset and Death
,00/00	certificate be executed rding physician and ise as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of t								
O. Box a	death certif e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of of 9 □ Unknown	aldeath 3	⊒Ectopic ⊒ Other (	pregnancy specify)				23d. Date of deliv	very Day Year
ecords, P	requires that the een signed by th nould be detache	þ	Part II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying	cause giver	n in Part I.				the cause of death?
Ē	: The law recate has been page 2 sho	Completed							24a. Wa aut per 1□ Yes	s an opsy formed? 2 🔀 No	prior to codeath?	topsy findings available ompletion of cause of 2 No
VII	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Othou	26. Place of Dea				
Sion or	ling After fune	tion: To	1 Yes 2XNo  27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		28c. Injury Work	4   Nursing F	lome 5X Res 28d. Describe		6 ☐Other (Spec iry occurred	ify)
DIVISI	= <b>5</b> th <b>6</b>	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, str fy)	reet, facto	ory, office			(Street ar own, State		ral Route Number,
	the Hospital hin 24 hours a the Funeral I npletely filled	edical	(Check only 2 Medical Examone)	nysician: To the best of my knominer: On the basis of examinated and manner stated.		vestigati	on, in my op	inion, death occu		e, date an	nd place, and due	to the cause(s)
	To t	M	29b. Signature and title dicertifier	$\sim$			9c. License 041698				st 22, 2	
Ş	2		30. Name and address of person who Stephen C. Hami	Lton, M.D. 11	6 Defe		łwy.,	Ste.400	Annap	olis	, MD 21	401
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature				-			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 18 2007 5 ANE ODEL MARY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Takoma Park Montgomery Washington Adventist If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2K F May 2, Washington, DC 71 1936 577-46-9307 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland r 28a-f show notified at 10a. State 10b. County 1X Yes 2 No Riverdale MD Prince George's Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 20737 USA 4511 Sheridan Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No If Yes, Give r than "natural", or items the Medical Examiner me 11. Marital Status Black, White, etc. filed within 72 hours after 1 □ Never Married 2K Married White Specify: Maryland 21215-0036 1 ☐ Yes 2 ☒ No 2 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Laurel Hospital Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. Receptionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ages 1 and 2 should be fill and of Health and Mental Health and Mental Health and Tis marked oth y or other traumatic eventy Be Margaret Sword Edgar Brown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4511 Sheridan Street, Riverdale, MD Charles E. O'Dell/Husband Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. Fort Lincoln Cemetery Aug. 23, 2007 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig o neral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part. Enter the disease, or sen, ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as all onsequence of) disease or condition resulting in death) /Medical Bulmony Disease Examiner Obstutice Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed Due to (or as a consequence of) burial-Box 68760, attending physician for use as the buria Physician/Medical the 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2☐Fetal death 4☐Pregnant at time of death 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) signed by the a ☐Yes 2☐No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, by 1 Yes 2 No 3 Probably 4 ™nknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 1 ☐ Yes 2 ☑ No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ this 28b. Time of 28d. Describe how injury occurred funeral 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death After 1 Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: A etely filled in by the fu death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20063703 Jeseule Um, MD TODO CHILDLE NOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TALLOWA BARK, MO-SABYASACH WAR 31. Date filed (Month, Day, Year) AUG 2 2 2007 32. Registrar's Signature State Registrar

			1- For Amend #1	9a Per INF	Marylan G8/I	9/20/0	artmen rtificate	t of H e of L	ealth a	and Men	ıtal Hyg	iene g. No.	007	28405
п	Physici	ian	Decedent's Name (First, Middle ELLIS CRIP)		ON	TD					Date of Deat Month	Day	Year	
	/Medi	cal	ELLIS CRIPI  4a. Facility Name (If not institution			JR.	4h City	Town or	Location		UGUSI	_	2007 county of Dea	
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	Funeral Director		5. Social Security Number 222-26-6032	6. Sex 7. 1 ☑ M 2 □ F	Age (In yrs. 62	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min. Se	Date of Birth Month, Day,		9. Bi	rthplace (State or Foreign Country) elaware
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or La	cation							10d. Inside City Limits
	Marylan -f ehow	to	MD Cec	il	Ea	arlevi	ille							1 ☐ Yes 2X No
	or 28a	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citize	on of What C	ountry?
	ath wi	ral	6 Connecticu				2	1919	)			U.S.	.A.	
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Baltimore,	O O		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		ate	Place of Dispo semetery, crer	natory or o	ther place		Date				r Town, State
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			23a. Part. Enter the disease, or shock, or heart failure. List Immediate Cause (Finat	only one cause on eac	h line.	ιΛ				A RCD U	. ,	est,		Approximate Interval Between Onset and Death
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Box	ne death certificate be executed the ettending physicien and shed for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2□Feta nt at time of d	t death 3	Ectopic pro					23	d. Date of de Month	elivery Day Year
P.O.	res that the d igned by the be detached		Part It, Other significant condition	ns contributing to dea	th but not res	ulting in the u	nderlying ca	ause give	n in Part I		23e. Did tot	acco use	ocontribute	to the cause of death?
rds	quires en sigr uld be	ed by								_	1 □ Ye	es 2 🗆	No 3□F	Probably 4 Unknown
of Vital Records,	The law requires that the set has been signed by the page 2 should be detache	Completed									24a. Was a autops perforr	y ned?	prior to death?	
ital		0	25. Was case referred to medical						26. Place	e of Death (C)	1.15.00	e)	1 □ Ye	s 2□No
<b>)</b>	5 <u>v</u> 5	To B	examiner? 1 Tes 2 No	Hospital: 1 □ Inp	patient 2 🗆	ER/Outpatier	1 38 DO	A Othe	er: 4□Nu	ırsing Home	5 🗆 Reside	ence 6 (	□Other (Sp	ecify)
	B 5 6	ü	27. Manner of Death 1 SNatural 5 □ Pending		Injury Day Year)	28b. Time of tnitury		8c. Injury Work			Describe ho	w injury	occurred	
Division	Attending ir death. ector: After by the fune	lcat	2 Accident investig	ot be 200 Diago of	f Injury - At hr	ome, farm, str	M eet facton		/es 2□		Location (St	reet and	Number or F	Rural Route Number,
Οį	2 2 2 2	Certification;	4 Homicide determi	building	, etc. (Specif	y) , tami, sti	eet, lactory	, onice		251.	City or Town	, State)		idia riodig rambor,
	Hoepil 4 hour Funer ely fill	Medical	29a. Certifier (Check only one)	g Physician: To the be examiner: On the bas and manne	is of examina	wledge, death tion and/or in	occurred avestigation,	at the tim in my op	e, date an einion, dea	nd ptace, and a	due to the ca t the time, da	ause(s) a ate and p	nd manner a lace, and du	is stated. e to the cause(s)
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	01		30. Name and address of person	TOBRANNA	MAN	1 23a) (Type,	Print)	1 57	ree	T q	elko	~,	MD	21941
	Sta Registr	_	31. Date filed (Month, Day, Year) SEP 0 5	E*	gistrar's Signa		Se D							

			for State Registrar	State of M	arylan	d / Depa	artment o	f Healt of Dea	th and N ath	Mental Hyg	iene20	07	2841	)6
ı	Physici	an	1. Decedent's Name (First, Middle,							2. Date of Deat Month	h Day	Year	3. Time of Dea	
	/Medio	cal	Wilbur Gordon I		1		41. O't. T-			Aug		2007	1322	M
	Examir	ier	4a. Facility Name (If not institution, g Atlantic General		,		4b. City, Tov Berli		lion or Death		4c. County	cest	or	
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	Director		219-30-8743	1⊠M 2□F	72	Yrs.	Months D	ays Hou	urs Min.	(Month, Day, Oct 19,			MD	
	and **		Usual Residence of Decedent  10a, State 10b, County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Li	mits
	Maryl f eho	ō	MD Worces	ster		rlin							1 XYes 2	
	r 28a	rec	10e. Street and Number				10f. Zip Co	de		1	0g. Citizen of V	Vhat Cour	ntry?	
	th with	Funeral Director	9545 Honeysuckle	e Road			218	11			US	SA		
	tama tama	Juer	11. Marital Status	12. Was Decedent Armed Forces	?		Was Decedent	of Hispanio Cuban, Mex	o Origin? (Sp xican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ		
20	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※ Divorced	1 □ Yes 2 🔀 If Yes, Give Year or Dates:	No		1 □ Yes 2 □	No Spe	ocify:		Specify	Bla	ck	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hyglene. d other then "neturel", or itams 23e or 28e-f ehow event, the Medical Examiner must be notified at	ed	15. Decedent's	Education		16a. Dece	dent's Usual O	ccupation			16b. Kind of Bu	siness/Inc	dustry	
2	B. "na Medi	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or	5+)	(Give	kind of work d DO NOT use re	one during etired)	most of worl	king			,	
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and and	N 1 2 3	Be	17. Father's Name (First, Middle, La	st)						e (First, Middle, M	<i>Maiden Sum</i> am	10)		
Ĕ	es 1 and 2 should be of Health and Mental fitem 27 is marked or other traumatic eve	2	Henry Pitts  19a. Informant's Name/Relationship	(Type Print)		10h Mailir	na Addrass (S			Sterling Tal Route Number	City or Town	Ctata 7in	Code	
<u>8</u>	and 2 s ealth an n 27 is i		Barbara Horton/o							Berlin,			Code	
ē,	f Hea f Hea item		20a. Method of Disposition			lace of Dispo	sition (Name of matory or other	of	s Ru.		20c. Location -		own, State	
Ë	rages rent of ant: If it	] 1	1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐Removal from State cify)	•		-		a 08/1	5/2007	Delmar	DE		
Baitimore,	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Lie	censee		22	Name and A	ddress of F	acility			, ,,		
n —	897 5 8	2	544	7			618 Wes	st Rd.	Son Fu	neral Ho isbury,	me MD 2180	1		
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cause by one cause on each l	d the deat line.	h. Do not ent	er the mode of	dying, sucl	h as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Deat	
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a	Pne	umoni	a.						Orise( and Deat	
	/Medical Examiner		1000mily	Due to (or as	s a conseq	uence of):	•							
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	cuted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.										
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8/60,	cate be executed physicien and the burial-transit	dicai		d								-		
ο O O	death certificate be executed e ettending physicien and nd for use as the burial-transit	Physician/Me	IF FEMALE:	23c. If yes, outcome	e of pregna	ancy	-				22d Day			
n	death etter	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant a	2 Feta	Ideath 3	Ectopic pregn Other (specif				Mo	te of delive nth	Day Year	
j.	oy th	hys	9 Unknown	9□ Unknown		V-								
ν, Τ	å B B	by P	Part II. Other significant condition	s contributing to death	but not res	ulting in the u	nderlying caus	e given in P	Part I.	23e. Did tob	acco use cont	ribute to th	ne cause of death	1?
Sora	w requires been sign should be	ted								1 □ Ye	s 2 🗆 No	3 Prob	ably 4 Unkr	own
Č	- D 70	Completed								24a. Was a autops	y (	prior to co	psy findings avai mpletion of cause	lable of
	: The law cate has	S								perform	ned? (	death? I 🗌 Yes	2□ No	
VItal	Physician: T this certificat ral director, p	Be	25. Was case referred to medical examiner?	Hospital:				Other		th  Check only on				
0		٦.	1 Yes No 27. Manner of Death	28a. Date of Inj	ury	ER/Outpatier 28b. Time o			Nursing H	ome 5 Reside			y)	
<u>0</u>	Attending ir death. ector: After by the fune	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da	ay Year)	Injury	м	Injury at Work? 1 ☐ Yes	2 □No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
DIVISION	Attendi	Certification;	3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of In building, e	njury - At he	ome, farm, str	eet, factory, of	fice		28f. Location (St City or Town		er or Rura	l Route Number,	
5	pital or A ours efter ieral Direction by	Ce		1										
	Hoy Hos	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis	of examina	wiedge, deat tion and/or in	h occurred at to vestigation, in	ne time, dat my opinion,	te and place , death occu	and due to the carred at the time, di	ause(s) and ma ate and place,	inner as s and due to	tated. the cause(s)	
	To the Hos within 24 h To the Fur	Med	29b. Signature and title of certifier	and manner s	tated.		29c. Li	cense num	ber	2	9d. Date signe	d (Month.	Dav. Yeari	
	- 3 - DA		M.D	1117				0064			8/13/		/	
(	18		30. Name and address of person w	no completed cause of	death (Iten	n 23a) (Type.	Print)							
_ '	4		Atif Zeeshan	no completed cause of AQ H 97	733	Healt.	to coop	Dr've	e 8	erli'n	2181	1		
	Sta		31. Date filed (Month, Day, Year)											
	Regist	rair	nou I (	LUUI Galla	100 1	K K	and 1							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Parks Trinity Angel Rose 2007 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give-street and number) * Wiczmi es Lenter Regiona eninsula If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Days 16 1 □ M 2**X** F 215-77-0543 10/24/2006 9 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 1 X Yes 2 No Salisbury Wicomico Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21804 USA 205 Winterborn Lane, Apt. 3 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carrie Elizabeth Gore Anthony Allen Parks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 205 Winterborn Lane, Apt. 3, Salisbury, MD 21804 Carrie E. Parks/mother Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/17/07 Salisbury, MD Parsons Cemetery 22. Name and Address of Facility H8110way Funeral H0 501 Snow Hill Rd., Funeral Service Licensee Home Professional Association ., Salisbury, MD 21804 Javid H. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ILL NES VIRA disease or condition resulting in death) Due to (or as a consequence of) CLEP CIT S/1 READ / DEVELO MINT CLEA PARINE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) TEMPHUMA MSTABLLY DIABETIL INSIDITION HOL COCKSACE 14964 Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month 5 Other (specify) 4 Pregnant at time of death 9∏Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HO TO POUGA LANT ACY 1 Yes 2 No 3 Probably 4 Unknown DIABERTA INSTAIN TEND INSTABILIN 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2DNo 25. Was case referred to medical 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

001)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

8.

21864

29d. Date signed (Month. Dav. Year)

14.200)

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Directo

Funeral

Completed by

Be

Examine

Physician/Medical

Completed by

Be

2

Certification:

Medical

1 ☐ Yes

27. Manner of Death

2 Accident

3 Suicide

29a. Certifie

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Dag

1. Natural

2 No

5 Pending

investigation

goo, mas un

2007

6 Could not be determined

THM NU

Year)

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 900e.

Baltimore, Maryland 21215-0036

requires that the death certificate be executed burial-tra physician the. attending p the been signed by t should be detach page 2 s certificate

Box 68760.

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Records,

or Vital

director. this After thi funeral death.

Hospital or Attending Physician: Division within 24 hours after death

To the Funeral Director:
completely filled in by the 1 To the h

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1/04 HEARTH WAY DUING TLL egistrar's Signature

Hospital: 1 ☐ Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

2 ER/Outpatient 3 DOA

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

2045473

SAUSBUNY

1 ☐ Yes 2 ☐ No

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

07-06672 Jimmie Lynn Parks

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 28408

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Physicia		egistrar 1. Decedent's Name (First, Midd	lie,Last)							Date of Dea Month	Day	Year		ime of Death 310 hrs
' Exami		Jimmie Lynn	Parks							August 28	3, 2007			13 10 1115
		4a. Facility Name (if not instituti	on, give street and nu	ımber)	41	b. City, Tow		cation of	Death ·			County of D arroll	leath	,
		Carroll Hospital Center	er			Westmi	nster						Di-thi-	an /State of
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last bi	rthday)	If Under		If Under		8. Date of Bi	rth(MM/DI		oreign	ice (State or
Director		214-84-6780	1 <b>¾</b>	42	Yrs.	Months	Days	Hours	Min.	Oct :	31 19	964	Country	⁽⁾ MD
	L	Usual Residence of Decedent										-	140	Links City Limits
any		10a. State 10b. County		10c. City, Tow	n or Locatio	on				,				d. Inside City Limits
3 8 1	.	MD Ca	rroll	F	inksb	ura						31 1		Yes 2 <b>∑</b> ¶No
Maryland 28a-f show	황	10e. Street and Number				10f. Zip C	ode				10g. Citize	en of What	Country?	,
the Maryland a or 28a-f sho	Director	1004 Form W	22.7				210	048				USA		Lanc I
ith th		1804 Fawn W		cedent Ever in U.S.	13. Wa	s Decedent	of Hisp	anic Origi	in? (·Spe	cify Yes or N	0- 1	14. Race - A		Indian, Black,
death w	Funeral	1 Never Married 2 X	Married Armed F	Forces?	If Ye	es, specify	Cuban,	Mexican,	Puerto R	ican, etc.		Willia, C		
er de		3 Widowed 4 D	ivorced If Yes, Give Ye		1	Yes 2X	No	specify:				Specify:		nite
AD 21215-0036 2 should be fifed within 72 hours after h and Mental Hygien 27 is marked other than "natural", c 27 is marked other than "natural", c mante event, the Medical Examinez.	d by	15. Decedent's Education (Sp	or Dates:		a. Deceden	t's Usual O	ccupatio	on (Give k	ind of wo	ork done	16b. Ki	ind of Busir	ness/Indu	stry
2 hou "nat	ompleted	Elementary/Secondary (0-12	2) College (	(1-4 or 5+)					03010010					
36 hin 7 ee.	힐	10				Carpe							Emp.	loyed
21215-0036 uld be filed within 7. Mental Hygiene. marked other than c event, the Medical	S	17. Father's Name (First, Midd	le, Last)				1			First, Middle		Surname)		
215 be file ntal H rked	Be	unknown .								ith Ba		h. as Tourn	State 7i	n Code)
21 Duld I Mer mar ic ev	2	19a. Informant's Name/Relatio	nship (Type, Print )							ural Route No				
b, MD 21215-0036 and 2 should be filed within 72 hou teath and Mental Hygiene. Them 27 is thanked other than "unat traumatic event, the Medical Exa		Sherry Lynn	e Parks/wi	ife	180	4 Faw	n Wa	y F	inks	burg,	MD 2	21048 ocation - 0	City or To	wn, State
e, Nand I and Health		20a. Method of Disposition  1 Burial 2 **Cremati	ion 3 Removal	from State cren	natory or ot	her place)			00/	31/200	7			
MOCE Pages 1 lent of F ant: If i	1	4 Donation 5 Other		Car	roll	Crema	tion	ı, Ir	C		55.	Hamp	pstea	ad, MD
		21. Signature of Funeral Servi	ce Lichisee		²² P	PILLES	Address F UI	of Facility neral	Hon	ne and	Char	æl, I	P.A.	01157
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hysician		23a. Part I. Enter the disease, failure. List only one cau	or complications that	caused the death. Do	not enter t	the mode of	f dying,	such as c	ardiac or	respiratory a	arrest, snc	ick, or mean	-	Between Onset and Death
fedical	20.7	Immediate Cause (Final disea		alcohol into	xicatio	on							_	Dealii
_xaminer		or condition resulting in death	Due to (or as	s a consequence of):					۰,	. ,				
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Sox 687 leath certific e attending i	sician	1 Yes 2 No 9		egnant at time of death known	5 🗌 0	other (Spec	city)							
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b.O. that the	ি ৯	Part II. Other significant con		<b>9</b>	•					1	Yes 2	<b>√</b> No 3	Proba	ably 4 Unknown
uires	- G									24a. W		24b. V	Nere auto	psy findings available
ord; v requested	je Se										utopsy erformed?		prior to co death?	impletion of cause of
ecc he lav ate ha	Completed										es 2	No 1	<b>✓</b> Yes	2 No
T. T.	Ü	25. Was case referred to me	dical				26.Plac	_		only one)			7	
<b>/ita</b> //sicia	BO	examiner?	Hospital: 1	Inpatient 2 🗸 E	R/Outpatie		OOA	Other ₄		ng Home 5		ience 6	Other:	
of of g Phy g Phy fier ti	1: To	27. Manner of Death	28a. D	ate of Injury 2 onth, Day, Year)	28b. Time o	of Injury		ury at Wo		28d. Descr	ibe now in	ijury occum	ea	
on on ath.	ij	1 Natural 5	Pending Fnd	8/28/2007 I	nd 2:3	38 am		Yes 2		unk				al Danta Number Cit
ision in Atternation		2 Accident 3 Suicide 6 X	nvestigation 28e. F	Place of Injury - At hon	ne, farm, st	reet, factor	, office	building,	etc.	28f. Location	on (Street ¿n, Statę),	and Numb ay Finl	er or Rur	al Route Number, Cit
Division of Vital Records, Fours and Attending Physician: The law requires ours after death.  reral Director: After this certificate has been sign ental in the thing and director states of the found of the foundation on sone? A chould be	Certification:	4 Homicide	determined (Spec	Found: re	esidenc	ce			)					
Hospi 4 hou Fune			ng Physician: To the	best of my knowledge	e, death occ	curred at th	e time,	date and p	place, an	d due to the	cause(s) a	and manne	r as state	d. e cause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and the finneral Directors. After this certificate has been signed by the attending physician and the finneral Directors.	Completely Medical (	one) 2 ✓ Medical	Examiner: On the ba and mann	sis of examination and	d/or investig	gation, in m	y opinio	n, death o	occurreu	at the time, (	ate and p	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		nth, Day,Year)
	8 8	29b. Signature and title of ce	entitier	11		29		se numbe	er		- 1	_	•	III, Day, rear
WJL	1	XMIX	WX //	$\mathcal{U}$			0.0	.M.E.				ugust 28 ————	, 2007	
D		30. Name and address of pe	erson wto mpleted	cause of death (Item 2	23a)			172		100:				
	7.	Susan Hogan MD.	Assistant Me	edical Examiner	111 P	enn Stre	et, Ba	ltimore	, MD 2	1201				
	Stat	a 31. Date filed (Month, Day, Y	'ear) 32	2. Registrar's Signatur	е	,								
	istra	ALIC 9	0 2007	Glace S	4	MAN THE								
DHMH 17 Rev	1/2001	1			ORIGIN	NAL					OCME			

State of Maryland / Department of Health and Mental Hygien 7 28409 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** August 19. 2007 Fermin Enriquez PeBenito 3:45 P /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ft. Washington Prince George's 1710 Dauphin Drive If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Sex XAM 2□F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 83 Yrs. Oct. 19, Philippines 608-02-7344 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County r than "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2XX No Director Prince George's Ft. Washington Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1710 Dauphin Drive 20744 s filed within 72 hours after death v I Hygiene. other than "natural", or items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Filipino 1 Tyes 2XXNo Specify: Ď 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Administrator Steel Co. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any liquy or other traumatic event RDE. Be PeBenito Fernando **Isabel** Enriquez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Afrodita PeBenito/Wife 1710 Dauphin Drive Ft. Washington, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Premoval from State 08/27/2007 Evergreen Memorial Park Pasig, Manila, Philippines 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home PA also 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GASTRIC CARCINOMA Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Il-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): s the burial-Records, P.O. Box 68760, Physician/Medical ij. use as 1 ettending p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď Venous Thromboembolism 1 Yes 2 No 3 Probably 4XXUnknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 213 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Division of Vital After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🖫 Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA ဥ 1 Tes 2 XN0 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1XXVatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. ithin 24 hours after death.

o the Funersi Director: A

ompletely filled in by the fu 2 Accident 6 ☐ Could not be 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 29a. Certifier 数文 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 64153 08/21/2007 J 0 JS Mendoza 6 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8926 Woodyard Road, Clinton, Maryland Jose L. Mendoza 20735 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 2 2007 Registrar

			1 - For State Registrar	State of iv	raiylaii		tificate of			leg. No.	2007	28410
	Physic		1. Decedent's Name (First, Middle, Ira R.		sey				2. Date of Dea Month August	Day	2007	3. Time of Death 4:08
	/Medi Examir		4a. Facility Name (If not institution,	give street and number	·)		4b. City, Town, or	Location of Deat			County of Death	4.00
	\$100 E	S ₂ 20	8010 Snow Hill	Road			Salisbu	ry			Worceste	er
	Funeral Director		5. Social Security Number  215–36–2227  Usual Residence of Decedent		ge (In yrs. I 84	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day 9/15/1	, Year)		lace (State or Foreign try) cyland
	yland Now		10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	e-f st	ctor	Maryland Word	cester		Salisb	urv					1 ☐ Yes 2 ☐ <b>X</b> lo
	or 28	Director	10e. Street and Number				10f. Zip Code				en of What Coun	try?
	e 23e	eral	8010 Snow Hill				21804			US		
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or iteme 23a or 28e-f show event, tra Medical Examinar must be notified at	by Funeral	11. Marital Status  1   Never Married 2   Married 3   Widowed 4   Divorced	12. Was Deceden Amed Forces 1 □ Yes 2X If Yes, Give Year or Dates:	? INo	II.	Vas Decedent of Hi f Yes, specify Cuba □ Yes 2🕱 No	ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- to Rican, etc.)		4. Race - Americ Black, White, of  Specify: wh	
2-0	72 hou	ted	15. Decedent's	s Education		16a. Deced	ent's Usual Occupa	ation		16b. Kin	d of Business/inc	
21215-0036	filed within 7 Hygiene. ther than "r int, II'e Med	Completed	(Specify only highest	College (1-4or	5+)	(Give life. L farme	kind of work done of DO NOT use retired	furing most of woi )	rking		riculture	·
Maryland ?		To Be C	17. Father's Name (First, Middle, L. Marion L. Pusey						ne (First, Middle, Parsons	Maiden S	Surname)	
ary	d 2 should in and Men 7 is marks traumatic	-	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailin	g Address (Street a	and Number or Ru	ıral Route Number	, City or	Town, State, Zip	Code)
	an Beall n 2		Edna Bennett/co	ompanion			O Snow Hi	ll Rd.,	Salisbur	у, М	ID 21804	
Baltimore,	Se to		20a. Method of Disposition 1   Burial 2 □ Cremation 3  Under Cope 4 □ Donation 5 □ Other (Special Cope Cope Cope Cope Cope Cope Cope Cope		Wic	ometery, crem COMICO	sition (Name of natory or other place Memorial		7/07		isbury,	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Li	Censed	CKS	Park	Name and Address					ssociation )4
	V-10		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cause	d the death	. Do not ente	or the mode of dying	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between
68760,	riticate be executed ng physician and as the burial-transit	Aedicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or as Due to (or as d.	a consequ	ence of):						
P.O. Box 68	death cer e attendir od for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a	2 Fetal	death 3□	Ectopic pregnancy Other (specify)			23	3d. Date of deliver Month	y Day Year
	that I	y Ph	Part II. Other significant condition	s contributing to death t	out not resul	Iting in the un	derlying cause give	n in Part I.	23e. Did tot	acco us	e contribute to the	cause of death?
rds	w requires been sign should be	ed by	ATRIAL FI	BRILLAST	02				1 □ Ye	s 2 🗆	No 3 ☐ Proba	ibly 4 Onknown
Records,	The lay	Completed							24a. Was a autops perform	y	prior to com death?	sy findings available ipletion of cause of
/ita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					26. Place of Dea	1 ☐ Yes at the (Check only on		1 □ Yes 2	E 140
<u></u>	this ald the	၉	1 ☐ Yes 2 No			R/Outpatient		4 🗆 Hursing m	ome 5 Reside			
Division of Vital	Afte fune	Certification:	27. Manner of Death  1 □ Natural 5 □ Pending 2 □ Accident investiga		lry y Year)	28b. Time of Injury	28c. Injury Work M 1 □ Y	at ? ′es 2 □ No	28d. Describe ho	w injury	occurred	
D	tel or Attendrs after death	Certif	3 Suicide 6 Could no determine	ed   289. Place of in	ury - At hor c. (Specify)	ne, farm, stre	et, factory, office		28f. Location (St. City or Town	eet and State)	Number or Rural	Route Number,
	To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best raminer: On the basis of and manner st	i examinatii	vledge daulth on and/or inve	occurred at the time estigation, in my op	a date and place inion, death occur	and due to the ear rred at the time, da	iuso(s) a ate and p	nd manner as sta place, and due to	the cause(s)
	To the To the complete	¥	29b. Signature and title of certifier	ani-	, N	no	29c. License	number 06241	I		signed (Month, D	lay, Year)
j	Olly		30. Name and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person who have seen and address of person			23a) (Type, P	rint)	PIVISIO				•
223	Sta	te	31. Date filed (Month, Day, Year)	2007 32. egistr	ar's Signatu	re /	1.11.	, - , -	//	- '	,	21804

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 MARY ADELINE PINKNEY 12 2:18 a M August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3245 Walters Lane #201 Forestville Prince Georges If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 🔯 F 577-66-7865 1946 Washington, DC Director 60 Dec. 22, Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 ☐Yes 2KNo MD Forestville Prince Georges 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 3245 Walters Lane #201 20747 USA Funeral "natural", or items dical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 SNever Married 2 Married 2 X No 1 ☐ Yes 2 🔀 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Postal Clerk US Postal Service other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe Health and Mental em 27 Is marked o Fanniebell Cornwell James Pinkney, Sr. မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Fural Route Number, City or Town, State, Zip Code) 7112 Fairchild St. #204 Alexandria, VA. 22306 Vincent Pinkney/Son permit. Pages 1 ar Department of Heal Important: If Item 2 any injury or other 3 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Harmony Memorial Park 8-20-2007 Landover, MD. 21. Signature of Funeral Service Li Marshall s Funeral Home, Inc. 4217 9thSt. N.W. Washington, DC 20011 23a. Patr. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Diabetes Mellitus Sequentially list conditions, Due to (or as a consequence of) Examiner fany and immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): physician Physician/Medical the IF FEMALE nse If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No for 4□Pregnant at time of death 5 Other (specify) the 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2**X** No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 St Residence 6 Other (Specify) 1 XYes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 [Inpatient this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 ☐ Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide thin 24 hours at Hospital 29a. Certifier 1💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the Within 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2007 MD0057400 nk 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lynn A', Thomas, MD 1221 Mercantile Lane Upper Marlboro, MD. 20774

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) AUG 2 1 2007

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 107 281

					,	Cei	rtificate of	Death	Re	g. No.	U/	28412
	Dhamisi		1. Decedent's Name (First, Midd	le, Last)					2. Date of Death Month		Year	3. Time of Death
	Physici /Medic		Anna Eli:	zabeth Rh	oads				Aug. 22		T <del>O</del> al	935 PM
	Examin		4a Fecility Name (If not institution					4b. City, Town, or L	ocation of Death	4c. County	of Death	
			Oakland Nurs:				WILL 1 4 No.	0akla		G	arre	
l	Funeral Director		5. Social Security Number 168-26-0881	6. Sex 7. Ag	e (In yrs. last 88	birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, May 1,	Year) 1919	Coun	^{ace} (State or Foreign try) sylvania
	pug *		Usuel Residence of Decedent  10a. State 10b. County	,	10c. City, T	own or Lo	cation				10	Od. Inside City Limits
	e Maryla	ctor		arrett	,,		0akland					1 ☐ Yes 2 🛣 No
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Madisal Examiner must be nothined at	Funeral Director	10e. Street and Number  2 Lake Shore I	)rive			10f. Zip Code	21550	10	g. Citizen of W	hat Count USA	try?
	r deat	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. V	Vas Decedent of Yes, specify Cut	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-		- America	
Baltimore, Maryland 21215-0020	ours after al', or its Examin	þ	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	ried 1 ☐ Yes 2 🛣 N	lo		1□Yes 20XNo		, , , , ,	Specify:		ite
5-0	72 ho	Completed	15. Deceder (Specify only highe	nt's Education st grade completed)	1	(Give	lent's Usual Occu	during most of world	king 1	6b. Kind of Bu	siness/Ind	ustry
121	within 108.	ם	Elementary/Secondary (0-12)	College (1-4or 5	+)		DO NOT use retire	•		W-1	16	
d 2	Hygie ther t		8 17. Father's Name (First, Middle,	Last)		Sewi	ng macni	ne Operat	or le (First, Middle, M	Knitti aiden Sumame		711
au	d be ental	To Be	Robert S.	К1орр				Cora	1 1		ffma	n
ary	shoul and M amari umari	۲	19a. Informant's Name/Relations		1	19b. Mailin	g Address (Stree	and Number or Rui	ral Route Number,	City or Town,	State, Zip	Code)
Σ	and 2 alth a 27 is		Russell D. Rho	ads/ Son	4	2146	Larkspu	r Court,	Indian La	and, SC	29	707
ore	of He of He fitem r oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 □ Bemovel from State	сете	etery, cren	sition (Name of natory or other pla		Date 2	0c. Location - 0	City or To	wn, State
Ĕ	ment mant: I		4 Donation 5 Other (S		St. 1	Micha	el's Cer	netery 8	3/27/07 T	ilden 1	Coens	hip, PA
Bai	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene, Important: if item 27 is marked other than "natural, any injury or other traumatic event, the Medical Exa		21. Signature of Funeral Service	Licensee			. Name and Addr :ewart Fu	ess of Facility ineral Hon		S. Seco Land, M		t. 1550
			23a. Part1. Enter the disease, of shock, or heart failure. List	complications that caused	the death. C	Do not ente	er the mode of dy	ng, such as cardiac	or respiratory arres	st,		Approximate
Y	Physician		SHOCK, OF HEART IZHUTE. LIST									Interval Between Onset and Death
and the second	/Medical Examiner		Immediate Cause (Final disease or condition	a Athero	solono	Ki	cardio	vascedan	disease	(Asca	(0)	25 48
		h	resulting in death)	A /	Due to (or as	a conseq	uence of):					
	ned insit	u in						4 7			-	423
ń	executing and half-tra	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as	a conseq	uence of):				ļ	
68760,	ita be iysicia he bu	edicai	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as	a consequ	uence of):					
39 ×	E 2 8	2	resulting in dealin, East	d							1	
Вох	eath o	Iclan	Dort II. Other significant condition	and another the death by	d not recultie	- i= th	adadh dan an can ai	on in Boot I	00h Didash		teribusto to	the cause of death?
<u>Р</u> .	t the c by the tacher	hys	Part II. Other significant condition			g in the un	idenying cause gr	ven in Part I.				ably 4 Unknown
S,	gned gned be de	ξ	Itiz Merma	s demena								
Division of Vital Records,	To the Hospital or Attending Physician: The law requiras that the death ce within 24 hours after death.  To the Funeral Director: After this certificata has been signed by the attend completaly filled in by the funeral director, page 2 should be detached for us.	Completed by Physician/	Algherna hog Ky	pertension					24a. Was an perform	autopsy ed?	ava	re autopsy findings ilable prior to npletion of cause
Ä	ne lav a has age 2	E C	,						1C) Yes	2 <b>34</b> 0		leath? Yes 2□ No
<u>ta</u>	un: T tifficat tor, p		25. Was case referred to medica	1				26. Place of Deat	th (Check only one			
₹	ysick is cer direc	L P	examiner? 1 □ Yes 🎏 No	Hospital:	nt 2 ER/	Outpatient	3□ DOA Ot	The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon	ome 5□Residen		r (Specify	)
0	ng Ph therth meral	ä	27. Manner of Death  (★Natural 5 ☐ Pendin	28a. Dete of Injur (Month, Day		b. Time of Injury	28c. Inju Wo		28d. Describe how			
Sio	eath. or: A	cati	2 Accident investi	gation				Yes 2□No				
Σ	or Att	Certification:	4 ☐ Homicide determ	ined 28e. Place of Injubuilding, etc	ry - At home, . <i>(Specify)</i>	, farm, stre	et, factory, office		28f. Location (Stre City or Town,		r or Rural	Route Number,
	spital	O O	29a. Certifier Certifyin	g Physician: To the best o	f my knowled	ige, death	occurred at the ti	me, date and place.	and due to the cau	use(s) and mar	ner as sta	ated.
	ne Ho n 24 t ne Fur pletaly	edicai	(Check only 2 Medical one)	Examiner: On the basis of and manner sta	examination	and/or inv	estigation, in my	ppinion, death occur	red at the time, dat	e and place, a	nd due to	the cause(s)
	To the To the comp	Σ	29b. Signature and title of certifie	1011,	_		29c. Licen:			d. Date signed		
			I wald	/ Ticha	200		D	30035		08/23	1/20	707
		5	30. Name and address of person	who completed cause of de	ath (Item 23)			DRUK	OAKCAL	io Mi	0 20	520
	Stat		31. Date filed (Month, Day, Year)	32. Registra	r's Signature		9			, (6		
	Registra		AUG 2	4 2007	me &		13062					

amend line 16b per fd eaco hlth dept 8/20/07 dlw

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

**Physician** /Medical Examiner

1. Decedent's Name (First, Middle, Last) 2. Date of Death 15 Allen L. Rice August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Medical Center Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | Auc | 13 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 1943 Director 219-38-9536 64 Yrs. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location ral', or items 23a or 28a-f ehov Examiner must be notified at Maryland Baltimore Baltimore Direct 10e. Street and Number 10f. Zip Code 2323 Washington Blvd. 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 🎾 No Specify: 3 ☐ Widowed 4 X Divorced "natural" Completed The Medicul 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 10thCaregiver 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fit iment of Health and Mental H tant: If item 27 is marked oth 18. Mother's Name (First, Middle, Maiden Surname) William Rice Vidia Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 i or othar tra Elizabeth Turner(Sister) 532 Wilson Rd. Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or g0ce. 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 8 - 21 - 0721. Signature of Funeral Service Licensee Wanname Reges of & acilSons Mortuary, P.A. 821 West St. Annapolis, Md. y B. Recar M00483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cancer **Physician** Lung /Medical Examiner Sequentially list conditions, if any loading to immodulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed and the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal dea 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ Completed 1 XYes 2 🗆 No peen 24a. Was an has autopsy No No of Vital 1 ☐ Yes ours after death.
naral Diractor: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 30 DOA 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 5 Pending Injury investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 within 24 hours a To the Funaral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 00029571

2007 3:15 A M 4c. County of Death Anne Arundel 9. Birthplace (State or Foreign Maryland 10d. Inside City Limits 1 ☐ Yes 2X No 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry Baltimore General Baltomore Cener 20c. Location - City or Town, State Baltimore, Md. Approximate Interval Between Onset and Death rear 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

31. Date filed (Month, Day, Year)

AUG 2 0 2007

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Berez MB 2225 E Defense Hwy, Crofton MD 21114

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 200 1. Decedent's Name (First, Middle, Lest) 2. Date of Death **Physician** 15SELL 2007 RED 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3194 Rolling Road Edgewater Anne Arundel 6. Sex. M 2□F 8. Date of Birth (Month, Day, Year) 07/25/1923 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 84 Director 488-24-9504 Arkansas Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits 10h. County show 28a-f sh notified 1 Yes 2 No Anne Arundel Edgewater Director Maryland Pages 1 and 2 should be filed within 72 hours after death with the I nent of Heatth and Mental Hygiene.
ant; If Item 27 is marked other than "natural", or items 23a or 28a-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 21037 United States 3194 Rolling Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No W II-14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: **Vietnam** Completed by Specify: White 3 Widowed 4 □ Divorced er than "natur, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chief Engineer Merchant Marines 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfred Perry Russell, Sr. Mary Good ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Blucher/Daughter 3194 Rolling Road, Edgewater, Maryland 21037 item 2 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important; If it any injury or c 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kalas Crematory 08/20/2007 Edgewater, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. Signature of Funer 2973 Solomons Island Road, Edgewater, Maryland 21037 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on ea h line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician 6 MUNITS Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): as the burialphysician Completed by Physician/Medical attending IF FEMALE: use 23c. If ves. outcome pf pregnancy 23d, Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy 5 in the past 12 months? Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) ned by the a detached for 1 ☐ Yes 2 ☐ No 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page nerforme Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 20 No 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To KESIDENCE 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

the death certificate be executed or Vital Records, P.O. Box 68760, To the Hospital or Attending Physiciam: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ANNAPOUS

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only 29b. Signature and title of Aertifie

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29c. License number

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year) 200

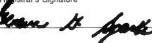
30. Name and address of per-31. Date filed (Month, Day, Year)

AUG 2 0 2007 32. Reistrar's Signature State

Registrar

Medical

6 ☐ Could not be



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 28415 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 18,2007 Edward Earl Roark August 10:27a™ /Medical 4c, County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Northwest Hospital Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. February 13, 1944 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F 63 Yrs. Director 222-28-1136 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 XNo Director DE New Castle Wilmington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or ? idical Examiner must be n 707 8th Ave. 19808 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) marked other than Truck Driver Construction permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grover Roark Chessie Wheatley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 8th Ave., Gloria Roark/Wife Wilmington, DE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) August N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Elkton Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Elkton, MD 22. Name and Address of Facility 21. Signature of Fyneral Service Licensee Andrew G. Gee Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Circhosis unknown /Medical Due to (or as a consequence of): Examiner Mepatitis C unknown Sequentially list conditions, it among the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Examiner as a consequence of death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an has autopsy certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient မ 2 ER/Outpatient 3 DOA this 28c. Injury at Work? I Director: After the in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours at To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 066171 August 18, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 MO JUSSq 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 28416

Paul Freeman Rawlings

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29b. Signature and title of certains  O.C.M.E. August 18, 2007  30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year)  32 Registrar's Signature	g Pl	1 =	27. Manner of Death		28a. Date of Injury (Month, Day,Year	280. 11116			-		Subject	struck	and pir	ined by	tractor
29b. Signature and title of certains  O.C.M.E. August 18, 2007  30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year)  32 Registrar's Signature	ri hadin	Į.	1 Natural 5 F			1400 hr		1	Yes 2	No					
29b. Signature and title of certains  O.C.M.E. August 18, 2007  30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year)  32 Registrar's Signature	Sic Vitter dear dear ctor	g	2 🗸 Accident	-	28e Place of Injur	v - At home, farm,	street, factor	y, office	building,	etc.	28f. Loca	tion (Stre	et and Nu	mber or F	Rural Route Number, City
29b. Signature and title of certains  O.C.M.E. August 18, 2007  30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year)  32 Registrar's Signature	or A	ΙĒ	3 Suicide 6			,					or To	_{own,} State ellv Roa	e) d, Rising	Sun, M	D
29b. Signature and title of certains  O.C.M.E. August 18, 2007  30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year)  32 Registrar's Signature	ital straight	Į,	4 Homicide												
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29b. Signature and title of certains  O.C.M.E. August 18, 2007  30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year)  32 Registrar's Signature	the I	<u> </u>	one) 2 Medical	Examiner: O	n the basis of examir	nation and/or inve	stigation, in m	ny opinio	n, death	occurred	at the time,	uate and	piace, ai		
30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year)  32 Registrar's Signature	To To t	<u> </u>		aı	na manner stated.	_						2	9d. Date s	signed (M	fonth, Day, Year)
30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year)  32 Registrar's Signature		2	Signature and title of Ce		1 //1			0.0	ME				August	18, 200	7
Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year) 32 Registrar's Signature		1		· nN	1. 18			0.0	., v , . L .						
Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	_	1	30 Name and address of n	rson who con	npleted cause of dea	ath (Item 23a)									
State 31. Date filed (Month, Day, Year)  32 Registrar's Signature	3			Deputy Ch	nief Medical Exa	aminer 111	Penn Stre	eet, Ba	ltimore	e, MD 2	21201				
State 31. Date filed (Month, Day, Year)															
		State				Signature	rede							nc	145

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 17

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician P en berg omas 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number **Examiner** n/a Marylano If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F 70 9, 1936 Maryland 213-32-3624 Oct. Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 X No Director Harford Aberdeen Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or ? must be r 21001 USA 508 Frontage Road Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23aury or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 14 Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: ۵ 3 ☐ Widowed 4 X Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Metal Fabrication Maintenance Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecelia Novak Matthew Reckenberger, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau once. 144 Camp Meeting Ground Road, Port Deposit MD 21904 Joan Adams/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State T. Foard Funeral Home, P.A. 4 □ Donation 5 □ Other (Specify) Rising Sun, Maryland 21. Signature of Funeral Service Li 22. Name and Address of Facility R. T. Foard Funeral Home, P.A. 111 S. Queen Street, Rising Sun, 239 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art failure. List only one cause on each line. Immediate Cause (Final disease pondition resultin in death) **Physician** /Medical Due to (r as a consequence of): Examiner MUCHUZIA Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (br as a consequence of): Examine r Attending Physician: The law requires that the death certificate be executed erebrovascula Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical OMUO Sax 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No autopsy Derformed 2 No 25. Was case referred to medical examiner?

1 Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours aller uccarry

To the Funeral Director A' 1 ☐ Yes 2 ☐ No death, 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide the Hospital TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and advress of person who completed cause of death (Item 23a) (Type, Print) Greene Stree Kamall Amin 31. Date filed (Month, Day, Year)  $\begin{array}{c} \text{AUG 2 2} \end{array}$ 32. Registrar's Signature State 2007 Registrar

Fune Direct

Physicia /Medic Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1	For State Registrar	C	ertificate of D	eath	Reg	No 2007	28418
siciar		1. Decedent's Name (First, Middle, Last)		· · · · · · · · · · · · · · · · · · ·		2. Date of Death Month	Day Year	3. Time of Death
edica		Mary Katherine Riggs				August	19,2007	2:30p ^M
minei		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	Location of Death		4c. County of Death	
. And		Union Hospital  5. Social Security Number 6. Sex 7. Age (In yr	s. last birthda	E1ktor	1 If Under 24 Hrs.	8. Date of Birth	Ceci1	L place (State or Foreign
ai or		215-28-5583 1 M 20 F 77	Yrs.	Months Days	Hours Min.	(Month, Day, Y	18,1929	VA
	-	Usual Residence of Decedent         10a. State         10b. County         10c. 0	City, Town or	Location			1	I0d. Inside City Limits
Š	3	MD Cecil	Elkt	on				1 ☐ Yes 2 No
Director	3	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cour	ntry?
		664 Appleton Rd.		219	921		U.S.A.	
Legonoria	5	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 10	B. Was Decedent of His If Yes, specify Cuban		ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	can Indian,
Š	2	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			Specify:		Specify: Whi	
100		15. Decedent's Education (Specify only highest grade completed)		cedent's Usual Occupa ve kind of work done du			b. Kind of Business/In	dustry
Completed	1	Elementary/Secondary (0-12) College (1-4or 5+)	life	. DO NOT use retired)		9		_
2	5	11 –		Housewife		(First Martin At	Househol	.d
á	5	17. Father's Name (First, Middle, Last)				(First, Middle, Ma	iden Surname)	
٤	2	Robert J. Sturgill	10b Ma	illing Address (Street ar		Weaver	City or Town State Zin	Code
		19a. Informant's Name/Relationship (Type. Print)						·
	- 1-	Russell K. Riggs/Son  20a. Method of Disposition 20b	. Place of Dis	1 Dixie I position (Name of	; [		on MD 2 c. Location - City or To	2.1921 own, State
		1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ilpin	rematory or other place Manor	Augus	st 23,	Elkton, M	ID
		21. Signature of Fune al Service Licensee		22. Name and Address Andrew	s of Facility  Gee I	Suneral		1001
	7	23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	ath. Do not e	enter the mode of dying	, such as cardiac	or respiratory arres	$\frac{2}{2}$ n, MD 2	Approximate Interval Between
		Immediate Cause (Final disease or condition	CON	robbil	Tolo	Who		Onset and Death
		resulting in death)  Due to (or as a cons	equence of):	-				
		Sequentially list conditions			•			
Evaminar	Ö	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	equence of):					
8		Cause (Disease or injury that initiated events c	nauonoo of):					
		Due to (or as a cons	equence or.					
locitor	5	d						
		IF FEMALE: 23c. If yes, outcome pf preg	inancy	-			23d. Date of deliv	an,
/ucivion/	5	in the past 12 months?	etal death	3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
107.0	2	1 ☐ Yes 2 ☐ ₩6 9 ☐ Unknown						
" Dh		Part II. Other significant conditions contributing to death but not r	esulting in the	underlying cause give	n in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
14		Sep815.				1 ☐ Yes	2 No 3 □ Prol	bably 4 ☐Unknown
Completed	100					24a. Was an		opsy findings available
2						autopsy performe 1□ Yes 2	prior to co death? 1 ☐ Yes	ompletion of cause of
	ט	25. Was case referred to medical			26. Place of Deat	n (Check only one)	LAIO 1 LE TES	213110
2	>	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2	☐ ER/Outpat	ient 3 DOA Othe	r: 4 Nursing Ho	me 5 Residen	ce 6 □Other (Speci	fy)
F	.	27. Manner of Death 1 ☐ Matural 5 ☐ Pending (Month, Day Year,	28b. Time Injur		at ?	28d. Describe how	injury occurred	
oito.		2 Accident investigation			′es 2□No			
ortification		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At building, etc. (Spe	home, farm, c <i>ify)</i>	street, factory, office		28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
(	ן כ							
looibol	12	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my leading to the basis of exam and manner stated.						
MA	2	and mainer stated.		29c. License	number	290	d. Date signed (Month,	Day, Year)
		Inh Vay 12	MI	2. 100	05795	3	872	5/0>
		30. Name and address of person who completed cause of death (II	em 23a) (Typ	29c. License 2 DO (	87 E	exw,	v 219	2/.
ate		31. Date filed (Month, Day, Year) 32. Projistrar's Sig	nature	1 4.	W /			
tra		31. Date filed (Month, Day, Year) 32. Figistrar's Sig	15	gove				
	4			4				

07-06279	
Issac Ross	

sac Ross	State of Maryland / Departmer 1- For State Certificat Registrar	nt of Health and Mental Hygic e of Death	ene 2007 284							
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last)	2. C M A	ate of Death Annth Day Year ugust 15, 2007  3. Time of Death 0356 hrs							
	Facility Name (if not institution, give street and number)     PG Hospital	4b. City, Town, or Location of Death Cheverly  4c. County of Death Prince George's								
Funeral Director	5. Social Security Number	hday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State Foreign D. Country)								
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside									
Maryland 28a-f show 1 at once, ector	D.C. Wash	ingtan  10f. Zip Code	1 Yes 2 No							
the Maryland Sa or 28a-f sh otified at once	4919 Jay Street, N.E.	20019	U.S.A.							
215-0036 be filed within 72 hours after death with the Maryland nital Hyggeine. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once. Be Completed by Funeral Director	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. 1 Armed Forces? 1 Yes 2 X No	<ol> <li>Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica</li> </ol>								
irs after or ural", o	Wildowed 4 Divorced in 1985, Give 1987 or Dates:	1 Yes 2 X No specify: cedent's Usual Occupation (Give kind of work	Specify:							
5-0036 led within 72 hours after bygiene. other than "natural", the Medical Examiner Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	ring most of working life. DO NOT use retired)  Maintence	Self							
21215-0036 Duld be filed within 7 I Mental Hygiene. I marked other than ic event, the Medica To Be Comple			st, Middle, Maiden Surname)							
2 5 8 5 0	19a. Informant's Name/Relationship (Type, Print )		Route Number, City or Town, State, Zip Code)							
MD and 2 sho salth and 27 is	Carolyn Ross - Sister 73	16 Serenade Circle; Clinta Disposition (Name of cemetery, Da	n, Maryland 20735							
5 8 2 E 5 I	1 Burial 2 Cremation 3 Removal from State crematory	or other place) s Cametery 08/25	East /2007 Dublin, Georgia							
Baltimo permit. Page Department o Important: injury or out	21. Surature of Funeral Service Licensee	22. Name and Address of Facility  Freeman Funeral Services	20748 4594 Beech Road; Temple Hill, MD							
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not cause on each line.	enter the mode of dying, such as cardiac or res	piratory arrest, shock, or heart Approximate Interval Between Onset and Death							
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Multiple Gunshot Wounds  Due to (or as a consequence of):									
2	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
ted 	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
execular and an and all - tra										
68760, certificate be uding physici se as the buriting the puriting th	IF FEMALE: 23b. Was decedent pregnant in the accept 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year							
the death certificate the death certificate by the attending phyched for use as the Physician/M	past 12 months?  4 Pregnant at time of death 5	Other (Specify)								
Records, P.O. Box The law requires that the death frate has been signed by the atte page 2 should be detached for the		n the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 ✔ No 3 Probably 4 Unknown							
Records, The law requires ficate has been signage 2 should be Completed			24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of							
of Vital Records, g Physician: The law requir wher this certificate has been s meral director, page 2 should t			performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No							
Vital Rechysician: The this certificate		26.Place of Death (Check only patient 3 DOA Other Nursing House								
on of Vital Is ending Physician: auth. or: After this certificate funeral director, thing in the funeral director, thing To Be C	27 Manner of Death 28a Date of Injury 28h Tit	النا النا	f. Describe how injury occurred bject shot							
	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farr	Location (Street and Number or Rural Route Number, City or Town, State)								
		occurred at the time, date and place, and due	9 Rochelle Avenue #1837, District Heights, MD to the cause(s) and manner as stated.							
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner:On the basis of examination and/or invalue and manner stated.  29b. Signature and title of certifier	estigation, in my opinion, death occurred at the 29c. License number	e time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)							
	Olive 52 =	O.C.M.E.	August 15, 2007							
De	30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Pe	enn Street, Baltimore, MD 21201								
State Registra										
registra		ØCI	ME							

DHMH 17 Rev 1/2001 OCME 2006

ended # 24a	a	1 - For State Registrar Per Phy, 9C,8  1. Decedent's Name (First, Middle, La:		Certific				g. No.	07	28420 3. Time of Death	
Physicia		William F	1, Sr			Aug. 18,		Year	3:15 PM		
/Medic Examin	_	4a. Facility Name (If not institution, give street and number) National Lutheran Home			4b. City, Town, or Location of Death Rockville			4c. County of Death Montgomery			
Funeral Director		5. Social Security Number 2 1 6 - 0 1 - 5 1 4 7 1  Usual Residence of Decedent	7. Age (In yrs. last b		nder 1 Year oths Days	If Under 24 Hrs Hours Min.		^{Year)} 7	Cou	place (State or Foreigi ntry) y Land	
h the Maryland or 28a-f ehow	ctor	10a. State 10b. County Md. Montg	wn or Location	Rockville					10d. Inside City Limits iX Yes 2 ☐ No		
th with the 23a or 28	Funeral Director	10e. Street and Number 9701 Veirs Dr	10	f. Zip Code 20	850	g. Citizen of	What Coul	ntry?			
5-UUSD 72 hours after death with the Maryland natural; or items 23a or 28a-1 ehow alfaal Examiner must be notified at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:			ecedent of H specify Cuba es 2 No	ispanic Origin? (S in, Mexican, Puer Specify:	14. Race - American Indian, Black, White, etc. Specify: White				
- c - a	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	a. Decedent's (Give kind of life. DO NO Sale:		rking	16b. Kind of Business/Industry  Welding					
should be filed withing Mental Hygiene.  marked other than matic event, ILEM	e	17. Father's Name (First, Middle, Last) William John Ruehl 18. Mother's Name (First, Middle, Machine (First, Middle, Machine)  Jean Olivia						Maiden Surname)			
		19a. Informant's Name/Relationship (	7				ural Route Number, Columbia	-			
Demit. Pages 1 and 2 should be appartment of Health and Menta mportant: If item 27 is marked by injury or other traumatic enter.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State No. 2 200	of Disposition ery, crematory POlita	(Name of or other place an Cr	ematory	Date 2 -8/21	oc. Location Alexa		own, State	
permit. Pag Department Important: eny injury o		21. Signature of Foneral Serve Licensee  22. Name and Address of Facility Hysony Co., INC  Wash., D.C.									
ysicia	by Physician/Medical Ex	23a. Part1. Enter the disease, or components shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CANDIOMYC  Due to (or as a consequence  Due to (or as a consequence  C. Due to (or as a consequence  C. Due to (or as a consequence  Due to (or as a consequence	ED ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) (	LMA Y	-V R E				Interval Between Onset and Death	
death cert a attendin d for use		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1							ery Day Year	
w requires that the been signed by the should be detached.		Part II. Other significant conditions c	ontributing to death but not resulting	in the underly	nderlying cause given in Part I.			Did tobacco use contribute to the cause of deal  1 Yes 2 No 3 Probably 4 Unk			
he law e has b ige 2 sl	Completed	/					24a. Was an autopsy perform	ed?/	Were auto prior to co death? 1 \( \text{Yes}	opsy findings available impletion of cause of	
Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	-	ath Check on one				
te in in	atlon: To	1 ☐ Yes 2 ☑ No  27. Manner of Death  Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Time of Injury	of 28c. Injury at Work? 28d. Describe how inju						
al or Attendii s after death. ii Director: A	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify)	farm, street, fa					eet and Number or Rural Route Number, State)		
Hospi 4 hou Funer Fely fill	Medical (	29a Certifier Certifying Ph (Check only one) 2 Medical Exam	iner: On the best of my knowledginer: On the basis of examination are and manner stated.	ge, daath onnii nd/or investiga	rted at the tin	na, date and place pinion, death occu	and dua to the caurred at the time, da	use(s) and m te and place,	anner as s and due to	ituled. o the cause(s)	
To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. License			d. Date signe			
ge		Mulle A			Do	0051158	A	UGUSS	19	2007	
18)	-	30. Name and address of person who of VATTI AWTHO W	ompleted cause of death (Item 23a) 9701 VLIRS	ORIVE	5	ROCKUII	LLE Y	10 20	850		
THE STATE OF	te	31. Date filed (Month, Day, Year) AUG 2 2 2007	32. Registrar's Signature								

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

**AUG 2 1** 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007 28422 8/21/07/WHD/SUCertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 11.51 AM DUISE 4a. Facility Name (If not institution, give street and number) TURGIS /Medical 4b. City, Town, or Location of Death Perlin 2/8/1 4c. County of Death Examiner 10270 Harrison Rd WOVCESTER Harri 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min 1 □ M 2 🕽 F 2/8-24-4074 Usual Residence of Decedent Director 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director WORCESTEA BERLIN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 81 ARRISON or Items 23a 10270 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: BLACK 3€Widowed 4 □ Divorced ear or Dates 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event. College (1-4or 5+) PRIVATE OMEST ORKER [AMILY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EORGE DRUMMOND ONQUES 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTEL 10270 - HAR 20b. Place of Disposition (Name of cemetery, crematory or other place) RD BERI KRIDDEL - HARRISON 2181 IN 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State MACEDONIA MEMORIAL 4 ☐ Donation 5 ☐ Other (Specify) 07 WESTOVER 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SMITH Duce 21801 LSABELLA CVI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** months resulting in death) /Medical Due to (or as a consequence of) Examiner ancer incleatic Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 XNo 3 Probably 1 Tes 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy this certificate 2 1 Yes 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one examiner Hospital: Other: 4 Nursing Home 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Mann of De 1 X Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 2 🗆 No death in by the Director 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Dire To the Hospital filled dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and tale of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of of death (Item 23a) (Type, Print) 31. Date filed (Month Day, Year) State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 28423

Nicholas Gregory	1 F	- For State Registrar		_		epartment o Ce <i>rtificate c</i>		nd Men	tal Hyd		g. No.	200	7 2842	
Physician Medical Examine	<i>V</i>									Date of Death Month August 17,		Year	3. Time of Death 1717 hrs	
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Division of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funcari Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the beating after the funeral director. To Re Completed by Physician Medical Certification:		29a. Certifier 1 (Check only one) 2	Certifying Physic Medical Examine		of examination									
	ž 7	29b. Signature and	title of certifier	1				nse number					nth, Day, Year)	
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6	[	30. Name and addr Zabiullah Al		completed caus stant Medica	,	•	nn Street, Ba	altimore, I	MD 2120	 )1				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Melissa Mae Sluss 200-AUQUS+ /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Medica If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 M 2 XF 218-84-5573 37 May 31,1970 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Charles Bryans Road 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6929 Skyline Place 20616 U.S.A. by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∏ Yes 2 🙀 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. Specify: 3 Widowed 4 Divorced White Year or Dates: "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 0 Never Worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Baze Sluss Yvonne Graham ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 440, Bryans Road, Md. 20616 Yvonne Sluss Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Nazarene Church Cemetery Burial 2 Cremation 3 Removal from State 17, 2007 Pisgah, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility
Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. 20640 M00668 ase, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one puse on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the dis shock, or hear fail Immediate Cause (Final disease or condition resulting in death) FURNAT 14 45 **Physician** 4 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed SEITLURG use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was ...
autopsy
performed?

ves 2 No page 2 s certificate 1□ Yes To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 COA this hours after death.

Ineral Director: After this
y filled in by the funeral di 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Year 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I 29a. Certifier 1 🗷 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State Registrar

art

Name and address of

31. Date filed (Month, Day, Year)

AUG 2 1 2007

rson who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

		1 - For State Registrar		aryland /	Ce.	artment of Herificate of L	ealth and N Death	Re	ien 2007	28425	
Physicia / /Medic		1. Decedent's Name (First, Middle, La Charles Edward						2. Date of Deat Month August	Day 2007	3. Time of Death 8:35P M	
Examin		4a. Facility Name (If not institution, give				4b. City, Town, or Port To			4c. County of Death Charles		
Funeral Director				69	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min. OC C	8. Date of Birth (Month, Day, ber 22,	9. Bir (937)	thplace (State or Foreign ountry) Ohio	
yland		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
he Mai	ector	MD Char	les	Port	Tol	10f. Zip Code			10g. Citizen of What Country?		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	ai Dir	8170 Rose Hill	Manor Place	9		20677	7		USA	ountly?	
	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 ☑ Yes 2 ☑ N If Yes, Give Year or Dates:		l l	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:		
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and M		19a. Informant's Name/Relationship	(Type, Print)				and Number or Rui	al Route Number	, City or Town, State,		
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/Medical Examiner		disease or condition resulting in death)  a. Due to (or as a consequence of):									
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cate be physici the bu	edical	•	d								
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	Completed				· · ·			24a. Was a autops perform	ried? prior to death?	cutopsy findings available completion of cause of	
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th. :: After this e funeral di	ation: To	1   Yes 2 No								ecify)	
al or Atter s after des il Director d in by th	Certification:	3 Suicide 4 Homicide  Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number City or Town, State)						treet and Number or F n, State)	Rural Route Number,		
To the Hospital or Attending Physician: thin 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director,	edical (		hysician: To the best miner: On the basis of and manner sta	examination a							
To II withii To If comp	Me	29b. Signature and title of certifier	- M Mc	th	_	29c. License	835	2	9d. Date signed (Mon	nth, Day, Year)	
3 104N	4	30. Name and address of person who	D0	3	La	Plate	mo	, 20	64 6 Krish	an Mathur,MD	
Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	*	book					

State of Maryland / Department of Health and Mental Hygiene 2007 28426 For Stata Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vivian 08-19-2007 Year **Physician** Virginia Simpson 6:00 p M /Medical 4a Facility Name (If not institution, give street and number) Charles County Nursing Center 4b. City, Town, or Location of Death 4c. County of Death Examiner La Plata Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 4 Month | 6 ay. 1 49 1 4 7. Age (In yrs. last birthday) 5 78-14-8525 9. Birthplace (State or Foreign Wash. DC **Funeral** 1 □ M 2 🔀 F Director Usual Residence of Decedent 10a. State MD filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Charles it. Pages 1 and 2 should be filed within 72 hours after death with the Marylan entment of Health and Mental Hygiene.
Itant: If item 27 is marked other than "natural, or itema 23a or 28a-f ehow njury or other traumatic event, the Medical Examinant in minital to notified at Waldorf YE Yes 2 No Director 102 Street and Number 11205 Barnswallow Pl. Apt. F 10f. Zip Code 20603 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ Specify: Black 3 Widowed 4 Vivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary Secondary (0-12) College (1-4or 5+) General Clerk Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Shields Sr. Virginia Alexandria 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11205 Barnswallow Pl. #F Waldorf, MD 20603 19a. Informant's Name/Relationship (Type, Print) Barbara Walker/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Memorial 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8-25-07 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) Monus 22. Name and Address of Facilin Ronald Taylor II FH permit.
Departn
Imports
any nju 21. Sign ture of Juneral Service License 108 W. North Ave. Baltimore, MD 21201 mound 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Obstructive Jaundice Physician /Medical Due to (or as a consequence ol) Pholangio Carcino ma Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Dav Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Hypertension 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Dementin 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death? After this certificate has autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation м within 24 hours after death To the Funeral Director: , completely filled in by the f 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building. etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) ihe I August 22 nd 29b. Signature and title of certifier 29c. License number Sindleum DOU61616 12007 11350 Pembroote Square WH dorf, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINDHW ANI RAVINDER 31. Date filed (Month, Day, Year) 32. Figistrar's Signature State 2007 Registrar

Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Joseph Sampugna 8 21 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University Park 4311 Tuckerman Street Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1⊠M 2□F 045-24-0702 75 Yrs. Director 09-27-1931 Usual Residence of Decedent 10c. City, Town or Location 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at Director Prince George's Maryland University Park 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or 20782 4311 Tuckerman Street U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Biochemistry Associate Professor Emeritius permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 Is marked other th any Injury or other traumath 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Antonio Sampugna Angela Augusta P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4311 Tuckerman Street, University Park, MD 20782 Dorothy Sampugna/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 8/22/07 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 MANA Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PROGRETSIVE LUNG CANCER resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine for use as the bunal-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 ☐Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacoo use contribute to the cause of death? δ RUBRA Vers YCYTHEMIA 1 res 2 No Completed 24a. Was an autopsy performed 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After 1 TO Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Funeral 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who ompleted cause of death (Item 23a) (Type, Print) Welenway Center Dr #215 Date filed (Month, Day, Year) 32. Registrar's Signature State

Reg. No. 2007

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 X Yes 2 ☐ No

New York

14. Race - American Indian,

Black, White, etc.

Specify: White

Month

Day

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

Year

2007

2:40 A. M

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 Decedent's Name (First, Middle, Last) 2. Date of Death August 16, 2007 **Physician** Stevenson Gregory 6:12 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Clinton Prince Georges Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | August 23,1956 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1**X** M 2 □ F 50 Director 577-92-3504 Washington, DC Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyghene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. MDPrince Georges 1X Yes 2 No Director Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20746 3600 Maywood Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ŽÎNo Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) National Gallary of Art Private 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cunningham Willie Stevenson Josephine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3600 Maywood Lane, Suitland, MD Agnes Stevenson/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 MBurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Sec. ftv) Resurrection Cemetery 8/22/07 Clinton, Maryland 21. Sign the of Funeral Service Lio 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd., Landover, MD 23a. Part 1. Soter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician bolows /Medical Due to (or as consequence of): **Examiner** Un Know -SARLOIDOSI Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical IF FEMALE: yes, outcome pf pregnancy
□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ျ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide l 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division or Vital Records, P.O. Box 68760 within 24 hours after death

To the Funeral Director:
completely filled in by the f the 13 B)

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State AUG 2 2 2007 Registrar

29b. Signature and title of certifier



- M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

8-16,07

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** AUGUST 2007 11:14a M 14 ANTHONY SANDERS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, Year)
Dec. 12, 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F Yrs. Dec. 1930 PA. 76 579-40-7849 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2X No Funeral Director Prince Georges Upper Marlboro Md 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 7 20772 USA 9404 Castle Drive 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 'natural", or Items dical Examiner m 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after a nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Iter 1 X Yes 2 □ No If Yes, Give Year or Dates: 4 -1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ed other than "natu 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Works 12th Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 Is marked or traumatic ev Beatrice Desper Joseph Sanders 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $1639\,$  Madison St  $_{NW}^{NW}$  Washington, D.C.  $20011\,$ 19a. Informant's Name/Relationship (Type. Print) Tonya A. Sanders/Daughter item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H
Important: If ite
any injury or ot
once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Cemetery 8-20-2007 Brentwood, MD. 21. Signature of Funeral Service Licensee Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, DC 20011 23a. Past Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-tra r as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Nonknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2X No certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ 69/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | Yo ဥ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6 n address of person who complete cause of death (Item 23a) (Type, Print) 7503 Surratts RD Clinton MD 32. Registrar's Signature State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		٠	For State Registrar		Ce	ertificate of		F	Reg. No. 2	007			
4	Physicia	an	1. Decedent's Name (First, Middle,			2. Date of Dea	Day	007	3. Time of Death				
	/Medic	al -	Ida Machado  4a. Facility Name (If not institution,	Santos		4b. City. Town, o	r Location of Death	August		JU / ty of Death	1:20 P M		
7	Examin	er	4495 Linthicu			Davton			Howard	l			
/C .	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthd					If Under 1 Year   If Under 24 Hrs.   8, Date of			of Birth 9. Birthplace (State or Foreign			
	Director		214-58-3091 1 M 2 F 76 Yrs. Months Days Hours Min. (Month, Day, Year) Sept. 17,1930								rtugal		
	and w		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location								I0d. Inside City Limits		
Ind 21215-0036  be filed within 72 hours after death with the Maryland tial Hygiene.  dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	ō	MD Howard	l	Day	ton					1 ☐ Yes 2 No			
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Cou	ntry?		
	th wit 23a o 1st be		4495 Linthicum	ı Road		210	36			SA			
	r dea tems er mi	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ace - Americ ack, White,			
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 █️XNo If Yes, Give Year or Dates:	0	1 ☐ Yes 2 📉 No	Specify:		Spec	eify: Whi	ite		
Maryland 21215-0036	2 houra	edt	15. Decedent's	s Education	16a. Dec	edent's Usual Occup	pation		16b. Kind of				
215	filed within 72 h Il Hygiene. other than "naturent, the Medica	Completed	(Specify only highest Elementary/Secondary (0-12)	college (1-4or 5+	(Giv	e kind of work done DO NOT use retire	during most of worki d)	ing					
2	ed wil ygien ier th	Con	12			Cook		·=:		aurant			
and	be fill ad oth even	æ	17. Father's Name (First, Middle, L				18. Mother's Name			ame)			
<u> </u>	2 should be and Mental Is marked aumatic ev	욘	Vicente Mach		19b Mai	ling Address (Street	Gertrud			n State Zii	Code)		
<u>8</u>	nd 2 s Ith an 27 Is		Isabel DeSousa			Linthicu	_	Dayton,		21036	,		
	- エッキ		20a. Method of Disposition			position (Name of ematory or other pla		Date	20c. Location				
Ë	Pages nent of l int: If its iry or o		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		1	Heaven Ce	1	/2007	Silve	r Spri	ing, MD.		
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service L	icensee		22. Name and Addre		all Fun	eral H	ome			
***	20 E # 9		Chus	n fowell		5512 NW Cr		Bowie		2071			
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	complications that caused to only one cause on each line	the death. Do not e e.	nter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)								1 week		
	Examiner		1	- 1	consequence of):	j					13 years		
		Jer	Sequentially list conditions, if any, leading to immediate	0.	consequence of):								
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause for non-ping Cause (Disease or injury that initiated events	с									
Ö,	e exe ian ar urial-t	I Ex	resulting in death) Last	Due to (or as a	s a consequence of):								
68760,	tificate be executed g physician and as the burial-transit	edical	· ·	d						-			
_			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p					23d. [	Date of deliv	erv		
. Box	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 4 ☐ Pregnant at t		□Ectopic pregnanc □ Other (specify) _	у			Month	Day Year		
o.	w requires that the de been signed by the should be detached	hys	9 □ Unknown	9□Unknown				_					
S,	gned be de	by P	Part II. Other significant conditio	ns contributing to death but	t not resulting in the	underlying cause give	ven in Part I.				he cause of death?		
ord	requir een si nould	ted						101	res 2 Mo	3∐ Pro	bably 4 □Unknown		
Records,	has by	Completed						24a. Was		prior to co death?	opsy findings available empletion of cause of		
	n: Th licate r, pag							1∐ Yes	2 No	1 ☐ Yes	2□No		
Vita	Physician: The la r this certificate have aral director, page 2	) Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1  Inpatier	nt 2 ☐ ER/Outpati	ent 3 DOA Ott	26. Place of Deather: 4 ☐ Nursing Ho	- 1		Whor (Case	6.1		
0	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injury	y 28b. Time	of 28c. Inju		28d. Describe h					
0	ath. or: After ne funera	atio	1 ☑Natural 5 ☐ Pending investig	ation	rear/ injury		Yes 2 □ No						
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	of be ned 28e. Place of injuing building, etc.	ry - At home, farm, s . <i>(Sp</i> ec <i>ify)</i>	street, factory, office		28f. Location (8 City or Tov		mber or Rur	al Route Number,		
	ours al		29a. Certifier 1 Certifying	g <b>Physician:</b> To the best o	f my knowledge, de	ath occurred at the t	ime, data and place	and due to the	oauso/s) and	mannor as	rinted		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical E	Examiner: On the basis of and manner state	examination and/or	investigation, in my	opinion, death occur	red at the time,	date and plac	e, and due	to the cause(s)		
	To the Hos within 24 hc To the Fun completely	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sig	ned (Month	Day, Year)		
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-	Colo		30. Name and address of person v				2		-				
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31. Date filed (Month, Day, Year)

Ling Li, MD

30. Name and address of person who completed cause of death (Item 23a)

32. Registrar's Signature

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:24 P M 27 2007 Howard Oden Trott, Sr. August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner 11332 Southern Maryland Blvd. Dunkirk Calvert If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, ) May 31, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Min Year Yrs. 216–18–5899 84 1923 Marýland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2X No Director Dunkirk MD Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 11332 Southern Maryland Blvd. 20754 Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No 1943— If Yes, Give Year or Dates: 1945 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: þ 3 Widowed 4 Divorced white Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 farmer agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winfield Trott Georgiana Moreland Howard 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11344 Southern Maryland Blvd. Dunkirk, MD 20754 Marsha T. Reinhardt, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion UMC Cemetery 08-31-2007 Lothian, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licenses 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cance Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

**Physician** /Medical **Examiner** 

permit. Page Department o Important: If any Injury or once,

**Funeral** 

Director

28a-f show 23a or 28a-f shovust be notified at

items

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite Lry or other traumatic event, the Medical Examine.

Baltimore, Maryland 21215-0036

ral", or item Examiner

with the Maryland

death

Division or Vital Records, P.O. Box 68760

Physician/Medical 2 Completed Be Certification: To

27. Manner of Death

Hospital or Attending Physician: The law requires that the death certificate be executed this After death. Director: filled in by the after To the Hospital within 24 hours a To the Funeral L

154

Jonathan Lowenthal, State

Medical

31. Date filed (Month, Day, Year) SEP 0 5 2007

29b. Signature and title of certifier

1 ☐ Yes 2 No

Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide



1 Inpatient

28a. Date of Injury (Month, Day Year)

Hospital:

5 Pending investigation

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 110 Hospital Rd., Ste. 310, Prince Frederick, MD 20678

2 ER/Outpatient 3 DOA

28c. Injury at Work?

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and practice stated. 29c. License number

1 ☐ Yes 2 ☐ No

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Sesidence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

Registrar

State

31. Date filed (Month

address of person who completed cause of death (Item 23a) (Type, Print)

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32. Broistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Dennis Thomas 2007 Mgust 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Lanham Doctors Community Hospital 8. Date of Birth 1942 9. Birthplace (State or Foreign (Month, Day, Year) Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number **Funeral** 1**⊠** M 2 □ F Louisiana 64 13 438-58-8553 December Director Usual Residence of Decedent 10c. City, Town or Location la or 28a-f show t be notified at 10a. State 10b. County 10d. Inside City Limits 1XIYes 2□No Director MD Landover Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20785 USA 1426 Capital View Terr. items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status "natural", or item edical Examiner n Armed Forces' Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ☐ Yes 2X No f Yes, Give 1 ☐ Never Married 2 ☑ Married 5-0036 Specify: Black 1 ☐ Yes 2 🖾 No Completed by 3 Widowed 4 Divorced Year or Dates: other than "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Driver Private 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked c August Thomas Rosie Marie Ernest P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1426 Capital View Terr., Landover, MD item 27 Naomi Miller Thomas/ Wife 20b. Place of Disposition (Name of semetery, crematory or other place Resurrection Cem. Date 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 3 Demoval from State 1 ☑ Burial 2 ☐ cremation 08/24/2007 Clinton, Maryland 4 Donation 5 ☐ Other (Speofy) 21 ignature of Funeral Arvi Alicensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd., Landover, MD 23a. Part1. Enter the disease, Trom the training that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each tree. Approximate Interval Between Onset and Death Immediate Cause (Final PULMONARY a ACUTE BM BO Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be executed Exami and burial-trai Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Ö Month in the past 12 months? Day Year 5 ☐ Other (specify) ☐Yes 2☐No the detached 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes RENAL PAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ABE has page 2 s autopsy performed certificate 1∐ Yes 2 No or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this neral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Injury the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

State

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32. Registrar's Signature

30. Name and address of person who completed cruse of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day,

29c. License number

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1- State Registrar Ameno#23aPrt.1.PerPhys.PCC8-28-07cCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Tatabod Arrest 1146 AM Bridge 2007 16 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (It not institution, give street and number, **Examiner** Batmore
1 Year | If Under 24 Hrs. Mary and Medical If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 31 none 26 1975 Cameroon Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County traumatic event, the Medical Examiner must be notified at MD Prince Georges tX Yes 2 No Greenhelt **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6000 Spring Hill Dr. #302 20770 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2½ No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private 2yrs Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emmanue1 Tatabod Alice Boma ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tatabod/ Sister 6000 Springhill Dr.#302, Greenbelt, MD Vivian or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Surial 2 Cremation Department o Important; If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Family Plot 9/14/2007 Bamenda, Cameroon J.B. Jenkins Funeral Home 21. Signature Funeral Se Me Licensee 22. Name and Address of Facility 7474 Landover Rd., Landover, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia ation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No 24a. Was an perform 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death. after death Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours af To the Funeral Discompletely filled in

State Registrar

29a. Certifier

29b. Signature and title of

and manner stated.

and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

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Physi /Med		1. Decedent's Name (First, Middle, Last)  Maravonda Wittman			2	Date of Dea	Day Year	3. Time of Death
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פו	il Hygi other /ent, t	Be Co	17. Father's Name (First, Middle, Las		L					(First, Middle		•		
yland	ould by Ments iarked	ToE	Dwight Williams	-						Christ				
Z Z	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship Nichole Christo		I .							or Town, State, MD 21804		
Baltimore,	ges 1 a t of He if item or othe	Г	20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3	Removal from State	1	cremato	ry or other plac			Date		ocation - City or	,	Ī
	it. Pagittmeni intent: injury		4 Donation 5 Other (Special Signature of Funeral Service Light	<u> </u>	Salisk		Cremato					lisbury,		_
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			23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	mplicatio of that caused to one cause on each line	the death. Do no e.	ot enter th	ne mode of dyin	g, such a	as cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. EXTREM Due to (or as a	E PRE	mai	urity							_
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o^	e execu an and irial-tra	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a	consequence of	):				····				
8/60,	icate be executed physician and s the burial-transit	dical	•	d	****									
ROX 6		n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p		۰.						23d. Date of de	elivery	
S S	w requires that the death certif been signed by the attending should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2 4□Pregnant at 1 9□Unknown			opic pregnancy her (specify)		<u> </u>			Month	Day Year	
7	that the		Part II. Other significant conditions	contributing to death bu	t not resulting in t	the under	tying cause give	en in Par	t I.	23e. Did	tobacco	use contribute t	o the cause of death?	
Suga	en sign	ed by								10	Yes 2	2 □ No 3 □ P	robably 4 Unknown	
Vital Records,	The law requires that the tte has been signed by th bage 2 should be detache	Completed								24a. Was auto	psy ormed?	prior to death?	utopsy findings available completion of cause of	
<u>ra</u>		Be Co	25. Was case referred to medical			_		26. Pla	ce of Deat	1 Yes	2□N one)	o 1 □ Ye	s 2 No	_
	hysici his ce I direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatier				4 🗆 Г	Nursing Ho	me 5□Res	idence	6 □Other (Spe	ecify)	
0 0	ling PI I. After t funera		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		jury	28c. Injur Worl M 1 □	yat k? Yes 2[		28d. Describe	how inj	ury occurred		
DIVISION OF	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director, I	Certification:	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 200 Place of inju	ry - At home, farr . (Specify)			-		28f. Location ( City or To			lural Route Number,	
ā	pital o		29a, Certifier 1 Certifying	Physician: To the best o	f mv knowledge.	death oc	curred at the tir	ne. date	and place.	and due to the	cause(	s) and manner a	is stated.	
	n 24 ho n 24 ho he Fun pletely	Medical		aminer: On the basis of	examination and	or invest	tigation, in my o	pinion, d	eath occur	red at the time	, date a	nd place, and du		
	To t To t	Σ	29b. Signature and title of certified				29c. Licens	e number	r		29d. D	ate signed (Mon		
}	Ont		30. Name and address of person wh	o completed cause of de	eath (Item 23a) (T	vne Prin	リ43 	108	_		(	08/17/20	07	
	- 111		ChrisTINE NETO	MD 100	E. CARR	oll	st.	Sali	sbun	Mel	218	01		
	Sta Registi		31. Date filed (Month, Pay, Year) AUG 22	2007 32. Fegistra	eath (Item 23a) (T	Local	alle)		/					
	3			B										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** WHITELOCK, JOHN Ε. /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death **Examiner** Wicerica JAIISDU If Under 24 H 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 1√2 M 2□ F Director 212-38-8273 69 1938 Maryland June l, Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 XYes 2 No Directo Salisbury Maryland Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 218 Spring Crest Drive 21804 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Dyes 2□ No 1956— If Yes, Give Year or Dates: 1958 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White Š 3 Widowed 4 Divorced 1958 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ene. than " College (1-4or 5+) Elementary/Secondary (0-12) Sales n and Mental Hygie Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be <u>Elpetina Brimer</u> 2 John Edwin Whitelock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau
once, Gayle M. Whitelock (Wife) Box 1497 - Salisbury, MD 21802 P.O. 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition cemetery crematory or other place)
Maryland Veterans Cemetery 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 8/24/07 Hurlock, Maryland 21. Signature of uneral Service Licensee 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME Robert H. Bradshaw, Jr. 306 W. Main Street - Crisfie

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 306 W. Main Street - Crisfield, Maryland 21817 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trans Division or Vital Records, P.O. Box 68760, the use as

been signed by the a should be detached f þ

Sequentially list conditions, if any, leading to financial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consuc	,				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Feta	Ideath 3 □Ectopic			23d. Date of de Month	elivery Day Year
ATHEROSCIEROT	IC CAKDION	ASWLA		1 ☐ Yes 24a. Was an autopsy performed	2 No 3 F	Probably 4 Unknown
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatient 3□			e 6 □Other (Sp	ecify)
27. Manner of Death  1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M ome, farm, street, fact y)	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
29a. Certifier 1 Certifying Phy (Check only 2 Medical Examione)	sician: To the best of my kno iner: On the basis of examina and manner stated.	tion and/or investigat	ion, in my opinion, death occ	curred at the time, date	and place, and du	ue to the cause(s)
The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	IF FEMALE: 23b. 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Was decedent pregnant     1   1   1   2   1   1   2   1   1	IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No 9   Unknown   20   Unknown   20   Unknown   25. Was case referred to medical examiner?   1   Yes 2   No   27. Manne of Death 1. Natural 2   Accident 3   Ectopic 28a. Date of Injury (Month, Day Year)   28b. Time of Injury   28b. Time of Injury   28c. Place of injury - At home, farm, street, fact of the control of the determined   29a. Certifier (Check only one)   29a. Certifier (Check only one)   1   Certifying Physician: To the best of my knowledge, death occurred and manner stated.	IFFEMALE:   23b. Was decedent pregnant   1	IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Yes   2   No   9   Unknown   1   Live birth   2   Fetal death   4   Pregnant at time of death   5   Other (specify)	That inhiated events resulting in death) Last    C

**ORIGINAL** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

614

14/MMARA

AUG 2 2 2007

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State

Registrar

Hospital or Attending

7 +1

within 24 hours after death.

To the Funeral Director: /

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month AUG **Physician** WHIMS 5:50 A M FRANCIS CHARLES 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOUSE FREDERICK KLINE HOSPICE If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 73 217-28-519 Yrs. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No FREDERICK FREDERICK MD. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HILLMEADE SQUARE U.S.A. Funeral within 72 hours after death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) US GOVERNMENT College (1-4or 5+) Elementary/Secondary (0-12) ELECTRICIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be WHIMS I HOM PSON LENORA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip,Code) 19a. Informant's Name/Relationship (Type. Print) ( WIFE FREDERICR Md. 21702 HILLMEADE SQ. WHIMS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2007 MEDERICA MD. ■ Burial 2 Cremation 3 Removal from State AUG. 23. PAIRVION Com. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CARY L. ROLLINS FUNCIONE IN WEST SOUTH ST PREDBUR MO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NON-SMALL CELL LUNG CANCER Physician 4 MONTHE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it are underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine certificate be executed burial-transi Due to (or as a consequence of): Records, P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) KLINE 25 No Hospital: 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Magner of Death 28b. Time of 28d. Describe how injury occurred Certification: After To the Hospital or Attending I within 24 hours after death.
To the Funeral Director; After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

DHMH 17 Rev 1/2001

State Registrar

(Check only one)

29b. Signature and title of certified

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEVENTA ST. 501 W. gistrar's Signatu

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	ate of Maryland		artment of H r <i>tificate of l</i>		, ,	jiene leg. No. <b>20</b>	07	28440
2	Discorded		Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th	Year	3. Time of Death
	Physicia Medic/		George H	. Wagner				8	Day 19	07	06 13 M
	Examin	er	4a. Facility Name (If not institution, give street			-	Location of Death		4c. County		
~			Carroll Hospital Cer 5. Social Security Number 6. Sex		ant histhday)	Westmi	nster If Under 24 Hrs.	8. Date of Birth		rroll	
П	Funeral Director			7. Age (In yrs. la	Yrs.	Months Days	Hours Min.	(Month, Day	(, Year)	Coui	place (State or Foreign ntry) Vland
ы			215-14-1774 Usual Residence of Decedent	84				ren 5,	1923	THEAT	yrana
	yland now at		10a. State 10b. County	10c. City	, Town or Lo	cation				1	10d. Inside City Limits
	e Mal	Director	Maryland Carroll	We	estmin	ster					Y Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code		1	10g. Citizen of	What Cou	ntry?
	ath w		700 Crows Ct. Apt			2115			USA		Jadiaa
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. W	as Decedent Ever in U.S med Forces? 194	3 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp ın, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Had Blad	ck, White,	can Indian, etc.
36	rs aft I",or xamil	by F	1 Never Married 2 Married If 3 Widowed 4 Divorced Ye	Z Yes 2 No 194. Yes, Give 1946	5	1⊡Yes 2√√2No	Specify:		Specif	v: Wh	iite
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n	should be filed within 72 hours after death with the Marylan and Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 12a or 28a-f show matic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Surnar	ne)	
<u>\Z</u>	should be and Mental s marked o	မ	Clarence Wagner		100 11 11			Hunter			
Maryland	an si		19a. Informant's Name/Relationship (Type. Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Prince Pr	*		ng Address <i>(Street a</i> <b>Crows Ct.</b>					21158
Baltimore,	es 1 and 3 of Health fitem 27 ir other tr		20a. Method of Disposition	20b. Pl.	ace of Dispo	sition (Name of matory or other plac	(e)	Date	20c. Location	- City or To	own, State
Ë	permit. Pages Department of Important: If it any injury or o once.		1 Burial 2 Cremation 3 Remov 4 Donation 5 Other (Specify)	ai irom State		on Ch. Cer	1	/2007	Finksbu	ra. N	Maryland
a	rmit. partn porta y inju		21. Signature of Funeral Service Licensee	TCASE.							Chapel, PA
<u> </u>	9 = E 5		John Kitte	)		2 Washing					L157
			23a. Pan1. Enter the disease, or complication shock, or heart failure. List only one cau	ns that caused the death use on each line.	. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory ari	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)		Sept	ric show	K				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of:						
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	uted d ansit	Examiner	Cause Disease or mility								
o,	exec an an		that initiated events c resulting in death) Last	Due to (or as a consequ	ence of):						
68760,	icate be executed physician and s the burial-transit	edical	d								
_		Med	IF FEMALE:					1000			
. Box	leath certific attending p for use as t	ian/	23b. Was decedent pregnant in the past 12 months?	yes, outcome pf pregnar □Live birth 2 □ Fetal	death 3 L	Ectopic pregnancy	,			ate of delive onth	ery Day Year
O	The law requires that the death certil ate has been signed by the attending page 2 should be detached for use a	Physician/M	1 T Ves 2 T No 4	□Pregnant at time of de □Unknown	atn 5L	Other (specify)	-				
۳.	that the ed by detac		Part II. Other significant conditions contribut	ing to death but not resu	Iting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to t	the cause of death?
Vital Records, P.O	quires n sign ald be	d by	Lung	cancer				1 □ Y	es 2 □ No	3 ☐ Prof	bably 4 <b>Y</b> Inknown
000	aw requir s been si should t	Completed						24a. Was a	an 24b.	Were auto	opsy findings available
Re	The la te has	mo						autop perfor 1∏ Yes	med?_	death?	ompletion of cause of 2□ No
<u>m</u>	rsician: The law s certificate has to lirector, page 2 s	BeC	25. Was case referred to medical examiner?			Ues.	26. Place of Deat			103	20110
<u>-</u>	Physic this ce al direc	10 0	1 Yes 2 No	al: 1 ☑ Inpatient 2 ☐ E	R/Outpatier		4 Liversing H	ome 5 🗆 Resid	lence 6 □Oth	ner (Speci	fy)
u u	ding Ph h. After th funeral		1 ☑Natural 5 ☐ Pending	a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl		28d. Describe h	ow injury occur	red	
Sio	tend leath. tor: / the fi	cati	2 Accident investigation	e. Place of injury - At hor	mo form etr		Yes 2 □ No	206 Leastien (C	Name of Alasma	has as D.	mi Pauta Alumbas
Division or	il or Attend after death I Director: / d in by the f	Certification:	4 Homicide determined	building, etc. (Specify		eet, factory, office		City or Tow	n, State)	er or Hun	al Route Number,
	spital nours neral / filled		29a. Certifier 1 Certifying Physician								
	To the Hospital or Attending Physician: within 424 hours after death.  To the Funeral Director. After this certifical completely filled in by the funeral director,	Medical	(Check only 2 Medical Examiner: (one)	On the basis of examinat and manner stated.	ion and/or in	vestigation, in my c	pinion, death occu	rred at the time,	date and place,	and due t	to the cause(s)
	Vithi To t	Σ	29b. Signature and title of certifier	A M. D		29c. Licens	e number	2	29d. Date signe	ed (Month,	
	and		I Hovel Sono						- /		
ノ	645		30. Name and address of person who completed was a factor of 2 m.  31. Date filed (Month, Day, Year)  AUG 2 0 2007	ted cause of death (Item う	23a) (Type,	Print)	Westn	ninsten	md.	211:	57
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	Coast o					
	Registr	ar	AUG 2 0 2007	Jacob 1	5 19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** -eoN August 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner VA Medical Center BALTIMORE 7. Age (In yrs. last birthday) Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 577-62-1818 60 2-19-1947 Director WASH. DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director DC WASHINGTON 10e. Street and Number 10g. Citizen of What Country? STREET, NE 534 21st Funeral 20002 U.S.A. 14. Race - American Indian, 12. Was Decedent Even in 66 – Armed Forces? 1 1 Yes 2 | No 1968 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired)
Medical Records Elementary/Secondary (0-12) College (1-4or 5+) VA Hospital permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If Item 27 is marked other tha any Injury or other traumette 17. Father's Name (First, Middle, Last)
Winter Williams 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah Cooper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $534\ 21st\ St.\ NE\ Washington\ DC\ 20002$ Glanzy Williams/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Riverdale Pk Crem. 8-27-07 Riverdale, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II FH 08 W. North Ave., Baltimore, MD 21201 21. Signature of Juneral Service Licenses mard 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Due to (or as a consequence of): **Physician** disease or condition resulting in death) 10 days /Medical Examiner sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine the death certificate be executed cenical sician and burial-trans cord Compression Due to (or as a consequence of) signed by the attending physician be detached for use as the buria Physician/Medical vetrophany need 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 2 → No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Natural To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760

Registrar

18/18

Medical

State

29a. Certifier (Check only one)

29b. Signature and title of certifier

and manner stated.

SAENZ

32. Reistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAENZ

31. Date filed (Month, Day, Year) AUG 2 2 2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

A44176435518218 8-18-2007

GREENE Street BALLIMORE MD 21201

Phy /N Ex

Fun Dire

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		for State Registrar		State o	f Marylan		artment of I rtificate of			, ,	gien Reg. N		דחו	201	10
/sicia	an	1. Decedent's Name (Firs		·						2. Date of Dea Month	ath Da	av	Year	3. Time of Dear	th C
ledic	al	JAMES  4a. Facility Name (If not it	EDWAR			WALTON	, JR.			AUGUST		7, c. County	2007	2:15P	M
amin	er	MAGNOLIA C		e sireei ano na	indery		LANHA		OI DOUGI		1		NCE GE	ORGES	
eral		5. Social Security Number		Sex XIXIM 2 □ F	7. Age (In yrs.	V	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day	ı, Year	r)	Countr	nce (State or For	
tor		579 42 5302 Usual Residence of Dece	2	/ta		74 Yrs.			J	JAN. 30	, 1	933	WASHI	ŃGTON, DO	<u>C</u>
E S	_	10a. State 10b.	. County		10c. Cit	y, Town or Lo	cation						10	d. Inside City Lin	
ошио	Director			GEORGES	C.	APITOL	HEIGHTS							XXYes 2□	]No
t be n		10e. Street and Number		ΔVENIIF			10f. Zip Code 2074	13					What Countr D STA'		
SE L	Funeral	11. Marital Status	NG TOTA		edent Ever in U	.S. 13.	Was Decedent of I		rigin? (Spec	ify Yes or No-		14. Rac	e - America	n Indian,	
amine		1 Never Married		XXYes	2		i Tes, specily Cut 1 □ Yes XX No			ican, etc.)			ck, White, et v: BLAC		
al EX	ed by	3 ☐ Widowed 4 ☐ I	Decedent's E	ducation	ates: 1952	16a. Deced	dent's Usual Occu	pation	-		16b. l		usiness/Indu		
any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify or Elementary/Secondary		ade completed) College (	1-4or 5+)	life. I	kind of work done OO NOT use retire	rd)							
Mt, tine		12TH 17. Father's Name (First,	Middle Lac	+)		BOILE	R ROOM CI	T		EER (First, Middle,				CHOOLS	
eve o	To Be	JAMES E. WA		,					LY CHI		Warde	n ouman	ie)		
aumar	_	19a. Informant's Name/F				19b. Mailir	ng Address (Street	and Numb	er or Rural	Route Numbe	er, City	or Town,	State, Zip (	Code)	
ner tra		MAGDALENE V		/ WIFE	100%		CARRINGTO	ON AVE		CAPITOL					
0 0		20a. Method of Disposition 1 ☐ Burial ※XXCre	emation 3 [		State	cemetery, crei	sition (Name of matory or other pla	· i	Da				City or Tow	•	
Indual		4 Donation 5 Other (Specify)  METROPOLITAN CREMATORY 8/27/2007 ALEXANDRIA, VA  21. Signature of Funeral Service Licensee  METROPOLITAN CREMATORY 8/27/2007 ALEXANDRIA, VA  22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746													
onc a		N. 4.	Win	kll			MARSHALL 4308 SUI	TLAND	ROAD	HOME C		MARYI ND, N	AND, I ID 2 <u>07</u>	NC. 46	
3		23a. Part 1. Enter the dis	ure. List only	plications that of one cause on e	caused the deat each line.	h. Do not ent	er the mode of dy	ng, such as	s cardiac or	respiratory ar	rest,			Approximate Intervat Between Onset and Death	n h
ian cal		Immediate Cause (Final disease or condition resulting in death)  a. PNEUMONIA  Due to (or as a consequence of):													
ner		Sequentially list conditions.  Due to (or as a consequence of):  MULTIPLE STROKES													
	iner	Sequentially list condition cause. Enter Underlying Cause (Disease or injury	ons, light	Due to	or as a conse	uence of									
al-transit	xamine	that initiated events resulting in death) Last		c	(or as a conseq	uence of):									
the buria	calE	<u>u</u>													
use as m	Physician/Medical	IF FEMALE:													
Tor US	lan/	23b. Was decedent preg in the past 12 mont	ths?	1 ☐ Live	tcome pf pregna pirth 2 ☐ Feta nant at time of c	al death 3	Ectopic pregnanc	ey .			- 1		te of deliver	y Day Year	
acneu	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□Unkn		Jean J	Other (specify)				Month Day Year				
completely filled in by the funeral director, page 2 should be detached for	by PI	Part II. Other significant		contributing to d	eath but not res	ulting in the u	nderlying cause gi	ven in Part	l.					cause of death	
nonia		DIABETES TY												bly XXUnkn	
ge z s	Completed	ATHEROSCLEI	ROTIC	CARD10V	ASCULAR	DISEAS	SE			24a. Was a autop perfor	SV	24b.	Were autop: prior to com death?	sy findings availa pletion of cause	able of
tor, pa	Φ	25. Was case referred to	o medical					26. Plac	e of Death	1□ Yes (Check only o	rmed? 2XXN ne)	lo	1 □ Yes 2	P□ No	
a allie	To B	examiner? 1 ☐ Yes 2 <b>XXX</b> No			<u> </u>	ER/Outpatier	C OLI BOX	ner: XX N		e 5 ☐ Resid		6 □Oth	er (Specify)		
runera	ion:		Pending		of Injury th, Day Year)	28b. Time o Injury	Wo	ry at rk? ]Yes 2 □	1	3d. Describe h	iow inji	ury occur	red		
by the	ficat		Could not b	e 28e, Place	of injury - At he	ome, farm, str	eet, factory, office	163 2					er or Rural	Route Number,	
ed In t	Certification:	4 Homicide		build	ing, etc. (Specil	·y)				City or Tow	n, Sta	te)			
itely III	edical			miner: On the	asis of examina		n occurred at the t vestigation, in my								
ompie	Mec		certifier	allu ma	ner stated.		29c. Licen	se number			29d. D	ate signe	d (Month, D	ay, Year)	
<u>,</u>		V	(		C.	Con	D32	2261			ΑU	GUST	21,	2007	
1		30. Name and address o			,			D #^	/, T A I	NTLIANE N	ντυ '	20704			
Sta	te	RICHARD FE 31. Date filed (Month, Da	ay, Year)		Registrar's Signa	a decision of	OLIS ROA	D #A	4 LA	NHAM, N	Ш	20/00			
gistr		AUG 22	2007	Baren	D. 1	Speck									

State Registrar

sion or Vital Records, P.O. Box 68760,	P	Baltimore, Maryland 21215-0036
tending Prysician: The law requires may the death certificate be executed eath. The trins certificate has been signed by the attending physician and tor: After this certificate has been signed by the attending physician and	hysi /Med Exam	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fien Z7 is marked other than "natural" or Items 23a or 28a-f show
the funeral director, page 2 should be detached for use as the burial-transit	cia lica	any injury or other traumatic event, the Medical Examiner must be notified at
	n al	once.

**Funeral** Director

	State of Maryland / Department of Health and Mental Hygiene 2007 28  1 - State Registrar Certificate of Death Reg. No. 2007 28	1443
Physiciar /Medica	Month Day Year	of Death
Examine Funeral	4a. Facility Name (If not institution, give street and number)  Southern Maryland Hospital Center Cliniton, or Location of Death  Cliniton, or Location of Death  Prince Geo  Social Security Number  239-66-0270  4c. County of Death  Prince Geo  Nonths Days Hours Min.  4d. County of Death  Prince Geo  Cunty Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country Of Death  Prince Geo  Country	
4	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside	
physician and Department of realm and Mental rygene.  Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show sthe burial-transit and superior of the traumatic event, the Medical Examiner must be notified at once.	Pope Funeral Homes, 5538 Marlboro Pike, Md.  23a. Pall E let the disease, or complic to a shat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.  Approximately the disease of the disease of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the	893 stville 20747
d by the attending physicis	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  23c. If yes, outcome pf pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown  23d. Date of delivery Month Day  4   Pregnant at time of death 9   Unknown  23d. Date of delivery Month Day  4   Pregnant at time of death 9   Unknown  23d. Date of delivery Month Day  4   Pregnant at time of death 5   Other (specify)	Year
cate has been signe page 2 should be d	24a. Was an autopsy performed?  1   Yes 2   No 3   Probably 4    24b. Were autopsy findin prior to completion of death? 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No	☑Unknown gs available
within 24 nours after death.  To the Funeral Director: After this certificate has been signed by the attending population of the funeral director, page 2 should be detached for use as	25. Was case referred to medical examiner? 1   Yes   27   No	lumber,
thin 24 hours a the Funeral lympletely filled	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.	
8	29b. Signature and title of certifier  V. Vormon  M.D  29c. License number 29d. Date signed (Month, Day, Year 8 - 16 - 07	7
State Registra	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIJAV SHRI KANNAN, 7-503 SURRATTS ROAD, CLINTON- MD 20735  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Appello  34. Appello	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007

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			For State Registrar	,	State of Ma	aryian		tificate o				Reg. N		20444
	Physici	an	1. Decedent's Name (First, Midd								2. Date of De Month August		ay Year	3. Time of Death
	/Media			r M. W				# Ch. T.		a of Dooth	August		c. County of Death	12:35 A. M
	Examir	ner	4a. Facility Name (If not institution Prince George's					4b. City, Towr	_	n or Death		Ē	Prince Georg	ge's
- B	Funeral		5. Social Security Number	6. Sex			last birthday)	If Under 1 Ye	ar If Und	er 24 Hrs.	8. Date of Bir (Month, Da	th	9. Birthp	place (State or Foreign
	Director		426-50-1664	1 🗆 A	4 250F	3	32 Yrs.	Months Day	s Hours	Min.	June 22			
	Du *		Usual Residence of Decedent  10a. State 10b. Count	,		10c Cit	ty, Town or Lo	cation						Od. Inside City Limits
	Aaryla ahor	5	D.C.				,,		washing	rtan				1√Yes 2 No
	289-i	rect	10e. Street and Number					10f. Zip Cod				10g. C	itizen of What Cour	ntry?
	3a or	Funeral Director	832 52nd Street,	N.E.					20	019			U.S.A.	
	deatl	ner	11. Marital Status		. Was Decedent I Armed Forces?	Ever in U	.S. 13.	Was Decedent of f Yes, specify C			cify Yes or No Rican, etc.)	)-	14. Race - Americ Black, White,	
920	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. do thygiene. do ther then "natural", or items 23s or 28s-f show event, Ite Medical Exercites must be recilied at		1 Never Married 2 Ma		1 Yes 2 XI If Yes, Give Year or Dates:	No	1	1 □ Yes 2X			, , , , , ,			ack
2-0	72 ho	eted	15. Decede (Specify only high	nt's Educa	tion completed)		/Give	dent's Usual Oc kind of work do	ne durina m	ost of worki	ng	16b. l	Kind of Business/In	dustry
7721	within iene. r then	Completed by	Elementary/Secondary (0-12)		College (1-4or 5	i+)	life. i	no NOT use reachbishop	rired)			R€	eligion	
Maryland 21215-0036	should be filed within nd Mental Hygiene. I marked other then umatic event, It e M	To Be C	17. Father's Name (First, Middle Jo		itchell				18. Moi		(First, Middle,		n <i>Sur</i> name)	
ary	shou and M is mar	-	19a. Informant's Name/Relation	ship <i>(Type</i>	o, Print)								or Town, State, Zip	
	i 1 and 2 Health a tem 27 la		Clara W. Hood (Da	ughter	·)		_						Wash. D.C	
Baltimore,	0,		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other	3 □Rer	noval from State	-	cemetery, crer	sition (Name of natory or other)	olace)	} 	2007		clocation - City or To	
Saltir	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr <u>onca</u> .		21. Signature of Funeral Service		1	)	22	. Name and Ad	dress of Fac	cility Ro	llins Fur	eral	Home, Inc	
	0 0 ≥ e q		23a. its/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct and Dr. Correct								Approximate			
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a.S	Due to (or as	a conseq	Ldua quence of):	e dr						Onset and Death
68/60,	icate be executed physician and the burial-transit	ai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as									
O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	230	c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	al death 3	Ectopic pregna Other (specify					23d. Date of deliver Month	ery Day Year
ds, F.	uires that signed b Id be dete	þ	Part II. Other significant condi	ions contr	ibuting to death b	ut not res	sulting in the u	nderlying cause	given in Pa	rt I.			use contribute to t	* 2
	The law requii ate has been s page 2 should	Completed									24a. Was auto perfo		prior to co death?	opsy findings available impletion of cause of 2 [] No
Vita	Physician: The this certificate rai director, pag	Be	25. Was case referred to medic examiner?		enital:		,		Other		(Check only			
5	Physi this c	2	1 ☐ Yes 2 😿 No 27. Manner of Death	ПО	spital: 1 ☐ Inpatie 28a. Date of Inju		ER/Outpatier 28b. Time o	II 3 DOA			me 5 Resi 28d. Describe		6 ☐Other (Special	(y)
lon	ath. r: After ne funer	ation	1 Natural 5 Pend 2 Accident inves	tigation	(Month, Da	y Year)	Injury	1	njury at Work? I 🗌 Yes 2		200, 20001120		, 5554.154	
Division	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	not be mined	28e. Place of Inj building, et			eet, factory, offi	ce		28f. Location ( City or To		and Number or Run te)	al Route Number,
	e Hospi 24 hour e Funer letely filk	edical	29a. Certifier 1 Certify (Check only 2 Medical	ing Physic I Exemine	cian: To the best er: On the basis er and manner sta	f examina	owledge, deat ation and/or in	h occurred at the vestigation, in m	e time, date ny opinion, d	and place, death occurr	and due to the ed at the time,	cause( date a	s) and manner as s nd place, and due t	stated. o the cause(s)
	To th within To th compl	¥ e	29b. Signature and title of certif	er	#		,		ense numbe				ate signed (Month,	
					luce	ex			D58	957		8	-20-0	7
	De		30. Name and address of person	who com	pleted cause of d	leath (Iter	m 23a) (Type,	Print)	DR		CHEVE	RL	-20-0 4, MD 2	6785
	Sta	ate	31. Date filed (Month, Day, Yea	0 1	32. Registr								/	7

State of Maryland / Department of Health and Mental Hygienes 28445 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 13^{Day} **Physician** Month 200^{Year} Margarette Jacqueline Williams 12:47 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3612 Anton Terrace Forestville P.G. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month. Day Year) 09/25/1932 **Funeral** 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2 🔀 F 74 579-48-4684 Director Washington, D.C. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "natural", or items 23e or 28a-f show other treumetic event, the Medical Examinating number be notified at 10d. Inside City Limits MD Forestville Directo P.G. 1 XYes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3612 Anton Terrace 20747 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status hours after ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ If Yes, Give Year or Dates: Specify: Black 3 ☐ Widowed 4 反 Divorced Completed e filed within 72 h al Hygiene. I other then "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) A.A.S. Nurse Private 17. Father's Name (First, Middle, Last) ages 1 and 2 should be fill of Health and Mental H: If item 27 Is marked oth 18. Mother's Name (First, Middle, Maiden Surname) Be William Grant Marrie Biles ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Angelia V. Williams-Coley/Daughter 3612 Anton Terrace; Forestville, Maryland 20747 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Pages Washington National Cem. 08/17/2007 1 € Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If ŏ Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) re of Fune of Service Lice 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hill, Maryland 20748 Enter the disease, or or heart failure. List mulications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician erotic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial Box 68760 Physician/Medical IF FEMALE use a 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? lor Day Month Year 5 Other (specify) 4 Pregnant at time of death P.O. 1 the 1 ☐ Yes 2 ☐ No 9 Unknown 9 🗌 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 Yes Hospitel or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely one) the License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) SAlvador Sylvester, M.D.; M.E. August 17, 2007 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Georges' Community Hospital Cheverly, Maryland 20785 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 2 2007 Registrar

			partment of Health and Mertificate of Death	Reg. N	<u>2001 28446</u>
Physi	cian	1. Decedent's Name (First, Middle, Last)  Josephine D. Williams			3. Time of Death
	dical	4a. Facility Name (If not institution, give street and number) Fort Washington Hospital	4b. City, Town, or Location of Death Fort Washington		. 2007   20:40 " Ic. County of Death Prince George's
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd: 579-48-4816 1□ M 2∏ F 71 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Oct. 3, 1	9. Birthplace (State or Foreign Country) 935 Washington, DC
:1215-0036 within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-1 show he Medical Examiner must be notified at	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of District of Columbia Washi	Location  Ington  10f. Zip Code	100.6	10d. Inside City Limits  MXYes 2 □ No  Citizen of What Country?
n with 3a or		4406 Quarles Street, NE #23	20019	_	United States
Ind 21215-0036  be filed within 72 hours after death with the Marylan lat Hygiene.  Indoorbar than "natural", or liams 23a or 28a-1 show event, the Medical Examinat must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes, Give A Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto     □ Yes 2□No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
215-0( thin 72 hou e. an "natura Medical E	Completed	(Specify only highest grade completed) (G	ocedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired)	ing	Kind of Business/Industry
Hygi othar	a	12 years Man  17. Father's Name (First, Middle, Last)	Power Development S  18. Mother's Name Mable 1	e (First, Middle, Maid	
	2	19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Rura Quarles St., NE #		
Baltimore, permit. Pages 1 a Department of Hec Important: If itam any Injury or otha		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State	crematory or other place)		Location - City or Town, State  Landover, Maryland
Balti permit. Departn Importa	OUC®	21. Signature of Funeral Service (Icense)	2 Name and Address of Facility St. 4001 Benning Road,	ewart Fune NE Washin	ral Home, Inc. gton, DC 20019
760, te be executed Examine Vsician and te burial-transit	ai	23a. Part Lenter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that indiated events resulting in death) Last  Due to (or as a consequence of):	a lung with Metas to	suld	Approximate Interval Between Onset and Death
. Box 68 death certifica e attending ph	Physician/Medica	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown  d.  23c. If yes, outcome of pregnancy 1  Live birth 2  Fetal death 4  Pregnant at time of death 9  Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
cords, P w requires that s been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobacc	o use contribute to the cause of death? 2 No 3 Frobably 4 Unknown
e la has	Completed			24a. Was an autopsy performed 1 Yes 2	
of Vital F Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	Other	h (Check only one)	
On of Viding Physician. After this cert funeral direct	tion: To	1 Yes 2 No  Hospital: 1 Impatient 2 EP/Outpa  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation  Hospital: 1 Impatient 2 EP/Outpa  28a. Date of Injury (Month, Day Year)  Inju	e of 28c. Injury at	me 5 Residence 28d. Describe how in	6 □Other (Specify) ijury occurred
Division of  To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
Div na Hospital or n 24 hours after ha Funaral Dir bletely filled in I	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, d 2 Madical Examiner: On the basis of examination and/of and manner stated.	eath occurred at the time, date and place, r investigation, in my opinion, death occur	red at the time, date	and place, and due to the cause(s)
To tha   within 2 To tha   complet	×	29b. Signature and title of ceptifier	29c. License number	29d.	Date signed (Month, Day, Year)
(4)		30. Name and address of person who completed cause of death (Item 23a) (Ty	D0055120	<u>u</u>	ug w, wo I
SC				washing to.	n DC 20032
Regi	State strar	AUG 2 2 2007 Free M. Souls			

State of Maryland / Department of Health and Mental Hygiene 7 0 7 28447 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yeer Month **Physician** 2007 9:15 A /Medical Helen Mary Wade August 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Sacred Heart Nursing Home Hyattsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 25 F 577-24-4022 86 Director Nov. 22, 1920 Washington, DC Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. ?7 is marked other than "natural", or iteme 23a or 28a-f shov traumatic avent, if a Medical Examinating the notitied at or 28a-f show 1√2 Yes 2 □ No Be Completed by Funeral Director Prince George's Fort Washington Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth with Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "nor any injury or other traument— any injury or other traument— 20744 United States 9523 Fort Foote Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White arcan 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: American 3 MWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private 12 years Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rosina Crawford Gilbert Cephas ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9523 Fort Foote Rd. Fort Washington, MD 20744 Sylvia Lewis - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Aug 21, 2007 Washington, DC Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Si mature of Funeral Service Name and Address of Facility Stewart Funeral Home, Inc. Licen 4001 Benning Road, NE Washington, DC 20019 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or learn failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocadial Infarction /Medical Due to (or as a consequence of): **Examiner** Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, nding physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death ete hes been signed by the a page 2 should be detached 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Progressive Cognitive Decline 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2□ No 1 ☐ Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury s after dea. 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD21524 August 17, 2007 30. Name and address of person while collipleted cause of areath (Item 23a) (Type, Print) Esmerando O. Juanitez, M.D. 1160 Varnum St., NE Suite 008 Washington, DC 20017 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 1 2007 Registrar

DHMH 17 Rev 1/2001

**Physician** Examiner

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

certificate ha

this

within 2.

Be

2

Certification:

Medical

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 ☐ No 1 Yes

(CI	heck only one)	
ne	5 Residence	6 ☐Other (Specify)
h8d	Describe how ini	ury occurred

Other: 4 Nursing Hor

28c. Injury at Work? 1∏Yes 2∏No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

D39037

08-18-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

1 Inpatient

(Month, Day Year)

28a. Date of Injury

MEDICAL PARKDAY, ANNOUS MO 21701 2001 DS MITCHELL MAMC

State Registrar

31. Date filed (Month, Day AUG 2 1 2007

29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 Tyes

27. Manner of Death

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

Natural

2000

5 Pending

investigation

6 Could not be determined

32. Registrar's Signature

2 ER/Outpatient 3 DOA

28b. Time of

Injury

			1- For State of Maryland / Dep	artment of Health and Mertificate of Death	ental Hygier	Z 8 1 1	28449
	Physici /Medic		1. Decedent's Name (First, Middle, Last) ALICE M. WILLIFORD		2. Date of Death	B ^{ay} 200°7	3. Time of Death 6:40 PM M
	Examir		4a. Facility Name (If not institution, give street and number) HCR MANORCARE LARGO	4b. City, Town, or Location of Death  LARGO		4c. County of Death P. G.	
I	Funeral Director		5. Social Security Number  5.78 60 8645  Cusual Residence of Decedent  6. Sex 1 □ M 25□ F  7. Age (In yrs. last birthday, 84 Yrs.)	Months Days Hours Min.	8. Date of Birth (Month, Day, Yes SEPT 23	9. Birth 9. Birth Coul 1922 WASI	place (State or Foreign ntry)  H. D.C.
	Maryland -f show	tor	10a. State 10b. County 10c. City, Town or L	ocation STVILLE			10d. Inside City Limits 1   Yes 2   No
	h with the 23a or 28a st be not	Funeral Director	10e. Street and Number 2909 SYDNEY AVENUE	10f. Zip Code 20747	10g.	Citizen of What Cou	ntry?
036	urs after deat al', or Items ? Ever Iter in	by	11. Marital Status  1 Never Married 2 Married  3 Waridowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2√√2 No Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, SpecifyBLAC	etc.
<b>Maryland 21215-0036</b>	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show eumatic event, the Medical Evantral for mastice or cilifical and an action of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of t	Completed	(Specify only highest grade completed) (Give	odent's Usual Occupation e kind of work done during most of workin DO NOT use retired) ESTIC	ng	Kind of Business/In	dustry
land		To Be C	17. Father's Name (First, Middle, Last) CHARLES E. LOVE		(First, Middle, Maid ENA CLIF		
	교육당학			ing Address (Street and Number or Rura 9 SYDNEY AVE. FO			,
altimore,	0 0		'4 □Donation 5 □Other (Specify) CEDAR H	HILL CEMETERY 8/	22/07	SUITLAN	D MD.
Ball	permit. Pag Department Important: I any injury o			2. Name and Address of Facility WAT 3435 14th ST., N.		ERAL HOM . DC. 20	E 010
50,	The law requires that the death certificate be executed the was been signed by the attending physician and bage 2 should be detached for use as the burial-transit	i Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	nal failure  and failure  and failure	r respiratory arrest,		Approximate Interval Between Onset and Death
x 68760	eath certificate I attending physi I for use as the b	/Medicai	IF FEMALE: 23c. If yes, outcome of pregnancy			Old Data of deliver	
.O. Box	at the death of the by the attentached for u	by Physician/Me	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		Month	Day Year
rds, P	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		co use contribute to the	he cause of death?
al Records,		Completed			24a. Was an autopsy performed 1 Yes 2	prior to co death?	psy findings available impletion of cause of
r Vital	Physicien: this certific	To Be	25. Was case referred to medical examiner?  1   Yes   2   No	26. Place of Death		6 ☐Other (Specif	(y)
sion of			27. Manner of Death  1 Autural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  (Month, Day Year)  28b. Time of Injury	of 28c. Injury at Work?  M 1 Tyes 2 No	28d. Describe how in	njury occurred	
DIVISION	itel or Att ins after de ral Directi led in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rura ate)	al Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Medicai	29a. Certifier (Check only one)  1□ Certifying Physician: To the best of my knowledge, deat control on the basis of examination and/or in and manner stated.  2□ Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a nestigation, in my opinion, death occurre	ed at the time, date a	e(s) and manner as s and place, and due to Date signed (Month,	o the cause(s)
	T Will		290. Signature and title of certifier  M.D. M.D. M.D. M.D.	D0063116		litlot	-aj, (oa)
	go			Print)  Boint Duive	Green	belt MI	20770
	Sta Registr		AUG 2 1 2007 Seven 32. Registrar's Signature 31. Date filed (Month, Day, Year)  M. Specker				

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- State of Maryland / Department of Health and Mental Hygiene 2007 28450  Certificate of Death Reg. No.
Physici	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year
/Medic	al -	MILL  4a, Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
Examin	ler	Doctor Community Hospital Lanham P.G.
Funeral Director		5. Social Security Number of Sex 17. Age (If yrs. last birthday) of Ste-44-\$195 of Sex 1 of Months Days Hours Min. Sex 1 of Birth (Month, Day, Year) of Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Birth (Month, Day, Year) of Sex 1 of Months Days Hours Min. Sex 1 of Birth (Month, Day, Year) of Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours Min. Sex 1 of Months Days Hours M
D D		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
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and 2 s ealth an n 27 is er trau		Cassandra Ali Mahon-Burnes 25 Canfield Road Yonkers, N.Y 10710
Pages 1 ant of He		20a. Method of Disposition 20b. Place of Disposition (Name of cernetary, crematory or other place) 20c. Location - City or Town, State
permit. Pages Department of Important: If i any Injury or once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  Carlot C. Donatas  Carlot Mc Culloh St. Balto. Ud. 21217
a m Dem		Carlow C. Dondars Carlo VicCullok St. Balto. U.S. 21217
Dhyaisian		23a. Part1. Enter the disease, or complications trial daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.  Immediate Cause (Final  Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):
Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. SECSS Due to (or as a consequence of):
outed cuted ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  PELY/C ABSCESS
be executed sician and burial-transit		resulting in death) Last  Due to (or as a consequence of):
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	O. DIVERTICULITIS
ath cer attendir for use	Physician/M	IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months?   2   Fetal death 3   Ectopic pregnancy 23d. Date of delivery   Month Day Year
t the de	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown
res tha signed be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 Livo 3 Probably 4 Unknown
w requirements	Completed	24a. Was an 24b. Were autopsy findings available
The la ate has page 2	Somp	autopsy performed? death?  1
scertificate ha	o Be (	25. Was case referred to medical examiner?  1 Yes 27 Ho  Hospital: 1 Department 2 DER/Outpatient 3 DOA Other: 4 Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of the Designation of
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tal or A s after al Direc	Certification:	4 Homicide determined determined building, etc. (Specify) building, etc. (Specify)
Hospi 24 hour Funer stely fill	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
To the within 2	Mec	29b. Signature and title of certifier.  29c. License number  29d. Date signed (Month, Day, Year)
		bur cry 861552 09-05-07
2		80. Name and address of person who completed cause of death (flem 23a) (Type, Print)  Kray Ereau A.D. 8/18 GOOD LUCK ROAD, LAWHAM, MD 30706
Sta Registr	te	31. Date filed (Month, Day, Year). 32 Registrar's Signature

DHMH 17 Rev 1/2001

AUGUST

**Physician** /Medical Examiner The law requires that the death certificate be executed burial-transi and Division or Vital Records, P.O. Box 68760,

with the Maryland

Pages 1 and 2 should be filed within 72 hours after

and Mental Hygiene.

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traumatic event,

altimore, Maryland 21215-0036

r than 'natural', or items 23a or 28a-f show the Medical Examiner must be notified at

physician the se as attending

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To the Hospital or Attending Pl within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral State Registrar

4 Homicide

29a. Certifier (Check only

1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number RES-000 29d. Date signed (Month. Dav. Year) August, 27

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VERONIQUE

31. Date filed (Month, Day, Year) 0 6 2007 32 Registrar's Signature

NUSSENBLATT, TOHASHOPKINSHOSPITAL, 600 NOTH WOLFE Street, Bulhmore MD

21287

DHMH 17 Rev 1/2001

07-06533	
Maurice Burton,	Ш

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	,		1- For State Registrar	or waryland i		cate of De		a Werka		g. No. 200	07 2845
Phy Medical Ex	ysicia xamii	ın/	Decedent's Name (First, Middle, Li Maurice	ast)	Bu	rton, 1	11		2. Date of Deat Month August 23		3. Time of Death 1309 hrs
			4a. Facility Name (if not institution, g 628 North Eutaw Street	ive street and number)			ity, Town, or altimore	Location of De		4c. County of Dea	ath
Fun Dire				Sex 7. Age	(In yrs. last t		Under 1 Yea onths Day		4in	-1947 9. E	
land	or 28a-f show any fied at once,	-	Md. 10b. County NA		•	vn or Location Baltimo					10d. Inside City Limits 1 X Yes 2 No
ı the Mary	3a or 28a- otified at	Director	10e Street and Number 628 N. Eutaw S	Street		10f	Zip Code 212	201	10	g. Citizen of What Co USA	ountry?
r death with	or items 2. must be n	Funeral	11. Marital Status  1 Never Married 2 Marrie	1X Yes 2	Ever in U.S.	If Yes, s	pecify Cubar	n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	White, etc.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 nours after death with the Maryland Department of Health and Mental Hygiene.	tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoo or other traumatic event, the Medical Examiner must be notified at once.	sted by	3 Widowed 4 X Divorce 15. Decedent's Education (Specify  Elementary/Secondary (0-12)	ed If Yes, Give Year or Dates: only highest grade com College (1-4 or 5		a. Decedent's Us				Specify: B1	
5-0036 ed within 7 tygiene	other than h. Medica	Completed	12th grade 17. Father's Name (First, Middle, Las			Custod	ial T	18.Mother's Na	me (First, Middle, M		Hospital
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fimore it. Pages 1 a	rtant: If it y or other t		1 X Burial 2 Cremation 3 4 Donation 5 Other Speci 21. Signature of Funeral Service Lice	fy:	te crem	rison F	lace)	Vet.	9–10–07	Owings M	ills, Md.
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Physic /Med ˈxam	lical		23a. Part I. Enter the disease, or corfailure. List only one cause on Immediate Cause (Final disease or condition resulting in death)		nerosclero				c or respiratory arre	est, snock, or neart	Approximate Interval Between Onset and Death
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<b>760,</b> icate be exec	physician and the burial - transit	Medical	UNPENDED IF FEMALE:	AMENDED						Tool Date of delike	
Box 6876 e death certifica	attending or use as	sician/	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcom  1 Live birth 4 Pregnant at t		2 Fetal de	eath 3 (Specify)	Ectopic pre	gnancy	23d. Date of deliving Month	Day Year
P.O. E	de të		Part II. Other significant condition	s contributing to death	but not resul	ting in the under	lying cause	given in Part I.			to the cause of death?
re	his certificate has been sign director, page 2 should be	Completed by	Diabetes meinus						24a. Was autop	an 24b. Were sy prior to death'	autopsy findings available o completion of cause of
ital R ician: 1	s certific rector, p	Be	25. Was case referred to medical examiner?	Hospital:	, a  = = =	/Outpatient 3	26.Place	of Death (Che		Desidence of Con	
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Division Atte	eral Director: illed in by the	Certification:	2 Accident Investigate 3 Suicide 6 Could not determine	ot be 28e. Place of Inju	ury - At home	, farm, street, fac	ctory, office I	ouilding, etc.	28f. Location (S or Town, S		Rural Route Number, City
Division To the Hospital or Attenc		edical	one) 2 Medical Examin	ician: To the best of my er:On the basis of exam and manner stated.							
		Σ	29b. Signature and title of certifier	Hell	200	~	29c. Licens	M.E.		29d. Date signed (A August 24, 200	
29			30. Name and address of person who Carol Alian, MD Assis	o completed cause of de tant Medical Exam		1) 1 Penn Stre	et, Baltim	ore, MD 21:	201		
R	Sta egist	ate rar	31. Date filed (Month, Day, Year) 2	007 32 Registrar	s Signature	Sparle	1				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** James Brown 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOMEWOOD GENIESIS BALTIMORE NA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1√M 2□F Months Days Hours 213-16-6996 Director 4-30-1923 84 Md. Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits be notified at Director Md. 1 XYes 2 No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 6610 Eastern Parkway 23a must Funeral 21214 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Black "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Disabled 5th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Ludier Lemon Fannie Pobinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olivia Nichols item 27 r other tra Sister-in-Law 6610 Eastern Ave., Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) = 5 permit. Page Department of Important: If any Injury or once. Cedar Hill Cem. 9-5-07 Anne Arundel Co., Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East Gla Warne 1101 E. North Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ADENO CARCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ DAMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed RENAL FAILURD 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an certificate has t irector, page 2 s autopsy performe 1∐ Yes 2 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 ☐ Mo P this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Division or Attending 1 Natural 5 ☐ Pending investigation Injury within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

To the Hospital within 24 hours at To the Funeral D the Hospital

State

Medical

(Check only one)

29b. Signature and title of certifie

HUMEWOOD

and manner stated

A7 TENDINY

PHYSICIAN

29c. License number

00062239

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29d. Date signed (Month, Day, Year)

SEPTEMBER 4 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yea **Physician** 22:59PM September / 2007 Martin Anthony Brandon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City, Town, or Location of Death Examiner LTIMORE ta If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Min **X**□M 2□F Director 218-84-5103 43 5-20-1964 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show at r 28a-f sh notified MD NA Baltimore 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or a 1005 Mt Holly Street 21229 U SA by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced er than "natura the Medical F Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unk Gaint Food Store permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Goldie Brandson, Sr Katie Brown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katie Brandon- Mother 1005 Mt Holly Street Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1√ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (*Specify*) King Memorial Park 9-7-2007 Randallstown, MD 22. Name and Address of Facility Signature di Funeral Service Licer March F/H 4300 Wabash Avenue Balto, MD 21215 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line.

Immediate Cause (Final disease for condition gesulfing in death)

Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tra Due to (or as a consequence of): ed by the attending physician detached for use as the buris Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy certificate 1∐ Yes 2 ☑ No director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 TER/Outpatient 3 DOA Certification: To 1 🗌 Inpatient al or Attending Ph s after death. It Director: After the 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and ad

JOM

9.00 allk 31. Date filed (Month, Day istrar's Signature 0

MD

ress of person who completed cause of death (Item 23a) (Type, Print)

D47353

Bultmore

2007

			State of Maryland / Department of Health and No. 1 - State Registrar Amend Item 26,27 per dr., g871,09/06/07dhb	Mental Hy	giene 200	7 28456
	Physici		1. Decedent's Name (First, Middle, Last)  Gregory A. Boblitz	2. Date of D Month		3. Time of Death
0	/Medic Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of	Death
	Funeral		5. Social Security Number  6. Sex 7. Age (in yrs. last birthday) If Under 1 Year If Under 24 Hrs.  7. Age (in yrs. last birthday) If Under 1 Year If Under 24 Hrs.  6. Year  6. Year  6. Year  6. Year  6. Year  6. Year  6. Year  7. Age (in yrs. last birthday) If Under 1 Year If Under 24 Hrs.  6. Year  6. Year  6. Year	8. Date of B	irth 9 ay, Year)	Birthplace (State or Foreign Country)
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	death with the Maryland ms 23a or 28a-f show r must be notified at	tor	10a. State 10b. County 10c. City, Town or Location MID Baltimore Middle River			10d. Inside City Limits 1 ☐ Yes 2 No
	vith the or 28a	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of Wha	at Country?
	eath v	Funeral	712 Wampler Road 21220  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sr	posific Voc or N	USA	American Indian,
> 9	after or ite	by Fun	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 2 □ No  If Yes, Give  1 □ Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No  If Yes 2 □ No	o Rican, etc.)		White, etc. White
0	72 hou "natura	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	king	16b. Kind of Busin	ess/Industry
Az Greg	d within giene. er than the Me	Completed	Elementary/Secondary (0-12)  12th  College (1-4or 5+)  Technician		Comput	er
5 pue	d be filed ental Hygi ked other c event, t	To Be (	17. Father's Name (First, Middle, Last)  Louis Boblitz  MAbel		e, Maiden Surname)	
(2/ arv	2 should and Mer Is marke aumatic	F	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Ru		ber, City or Town, Sta	nte, Zip Code)
-	t and 2 Health Health Health	3	Deborah S. Boblitz /wife 712 Wampler Road I	Baltim Date		
Bob	Pages 'nent of hint; If ite		20a. Method of Disposition  1℃ Burial 2 □ Cremation 3 □ Removal from State  4□ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Holly Hill Cemetery 8		20c. Location - Cit 7 Baltim	
W H	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; any Injury or other traumatic event, the Merkel Exal Exal Once.		21. Signature 11 meral prive Licence 22. Name and Address of Facility 30 Connelly Funera	00 Mac	e Ave. B	altimore MD
- 1			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. An exic Brain Injury  Due to (or as a consequence of):			Onset and Death
	Examiner		Sequentially list conditions b. Cardiac Arrest			
	uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
00	icate be executed physician and stee bunal-transit	Еха	that initiated events resulting in death) Last  Due to (or as a consequence of):			
68760	tificate big physic as the b	edical	d			
Vital Records. P.O. Box	Attending Physician: The law requires that the death certific refeath.  Totash. After this certificate has been signed by the attending py the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date o Month	*
rd S.	w requires that the been signed by should be detact	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			te to the cause of death?
l Reco	The law re ate has bee page 2 sho	Completed		24a. Wa auto peri 1 Yes	formged?   dea	re autopsy findings available r to completion of cause of th? Yes 2 □ No
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital: Other: Other:			
0 0	g Phys er this c eral dir	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		how injury occurred	Specify)
Division	tending Fleath.	catio	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Div	- 5 th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	City or To	(Street and Number of own, State)	or Rural Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled it	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation and manner at the time, date and place 2 medical Examiner: On the basis of examination and on the time, date and place 2 medical Examiner: On the basis of examination and on the time, date and place 2 medical Examiner: On the basis of examination and on the time, date and place 2 medical Examiner: On the basis of examination and on the time, date and place 2 medical Examiner: On the basis of examination and on the time, date and place 2 medical Examiner: On the basis of examination and on the time, date and place 2 medical Examiner: On the basis of examination and on the time, date 2 medical Examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the b	, and due to the rred at the time	e cause(s) and manne e, date and place, and	er as stated. I due to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (A	
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Rrint)		8/27/0	
	(2)		D. De bra Hutjen Franklin Square Hospital Genter, 90	NO Fran	elin Sc. D.	r. Batton Du 1237
	్ర Sta Registr		31. Date filed (Month, Day, Year)  SEP 0 6 2007		U	

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	Registrar			Certific	ate of Deat			Reg. 2. Date of Death	No.	3. Time of Death
Physician/ Medical Examiner	Phil		Foster		Breathwai			Month E September	Day Year 3, 2007 4c. County of Death	2335 hrs
	,	of Maryland Me			Baltin	rown, or Loca nore City			NA	1 == *1
Funeral Director	5. Social Security 225–02–9			(In yrs. last bir	thday) If Und Month Yrs.	_	Hours Min.	10 <b>-</b> 9-	(MM/DD/YYYY) 9. Bir Foreig Co	untry) VA .
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th the M 23a or 2 notified	1709 Me	ead Circle			13. Was Decede	21144	o Origin? / Sp	ocify Voc'or No.	USA	ican Indian, Black,
or death wi	11. Marital Status  1 X Never Mari	ied 2 Married	12. Was Decedent E Armed Forces?  1 Yes 2  If Yes, Give Year	No No	If Yes, speci		xican, Puerto I		White, etc.	186
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5-0036 ed within 72 hours lygiene. other than "natu the Medical Exan Completed	12th gi	rade	2 yrs.	,	Constur		-5			Construction
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altim	21. Signature of F	Other Specify uneral Service Licer	see	Car	22. Name and	1 A del	Facility	MarchaF+	HmoFestMd.	
m ឱ្យ ១ ខេ Physician	23a. Part I. Enter		lications that caused t	he death. Do		of dying, sucl	h as cardiac or	r respiratory arres		Approximate Interval
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To the Hospital within 24 hours a To the Funeral completely filled	_ Zaa. Certiller 1	Certifying Physic	ian: To the best of my r:On the basis of exar	v knowledge.	death occurred at the investigation, in r	ne time, date my opinion, de	and place, and eath occurred a	d due to the cause at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
To rou		nd title of certifier	and manner stated.			gc. License n	umber		29d. Date signed (M	fonth, Day, Year)
		com mi	ind , M.D.			O.C.M.	E.		September 4, 2	
07		Vincenti, MD	Assistant Medic		—	n Street, B	altimore, N	1D 21201		
Stat Registra			32. Revistra	r's Signature	. Sient					

ORIGINAL

07-06851 Timothy L. Brady Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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euicai Examiii			b. City, Town, or Location of Death		f Death
		University Hospital Shock Trauma	Baltimore	To Date of Birth (AMIDDOOON)	O Bisthalogo (State or
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  216-52-5110 1X M 2 F 58 Yrs.  Usual Residence of Decedent	If Under 1 Year If Under 24Hrs  Months Days Hours Min	_	Foreign West Country Virginia
	the latter land	10a. State 10b. County 10c. City, Town or Locati	on		10d. Inside City Limits
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21215-0036 within 7 Moital Hygiene. maked other than cevent, the Medical	Be	Willard Ray Brady Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing	Sarah S G Address (Street and Number or	Virginia Carpe	nter m, State; Zip Code)
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re, N s 1 and f Health if item er trau	1	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State crematory or ot	ition (Name of cemetery, her place)	Date 20c. Location	- City or Town, State
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Baltimore, MD permit Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumati		21. Signature of Funeral Service Licensee  Mod  13  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	Jame and Address of Facility Comas Funeral Ho 17 Cokesbury Ro	ad. Ahinadon, Ma	aryland 21009 Part Approximate Interval
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Box 687, death certificathe attending ped for use as th	Physician/	1 Yes 2 No 9 Unknown g Unknown	ther (Specify)		
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eco he law ate has age 2 s	omp			performed? 1 ✓ Yes 2 No	death? 1 ✔ Yes 2 No
Vital Rec ysician: The l this certificate l director, page	Be C	25. Was case referred to medical examiner?	26.Place of Death (Chec		
f Vit Physica er this caral dire	ToE	examiner? 1 Ves 2 No  Plant Inpatient 2 ER/Outpatier  27. Manner of Death  28a. Date of Injury 28b. Time of	. 6 56/.	sing Home 5 Residence 6  28d. Describe how injury occu	Other:
on of ending Pl th. r: After ne funeral		1 Natural 5 Pending Sep 3, 2007 1820 hrs	1 Yes 2 ✔ No	Operator of motorcycle	in collision
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should be	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local Street	eet, factory, office building, etc.	28f. Location (Street and Num or Town, State) Route 1 at Kalmia Road, D	ber or Rural Route Number, City ublin, MD
Division of ¹ To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Medical Ce	29a. Certifying Physician: To the best of my knowledge, death occur (Check only one)  Medical Examiner: On the basis of examination and/or investig.	urred at the time, date and place, a ation, in my opinion, death occurre	and due to the cause(s) and manned at the time, date and place, and	er as stated. due to the cause(s)
To wit con	Mec	29b. Signature and title of certifier	29c. License number		ned (Month, Day, Year)
		UMEZ	O.C.M.E.	Septembe	er 4, 2007
10 4		Name and address of person who completed cause of death (item 23a)     Ana Rubio MD. Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 212	201	
[ ]	tate				
Regis		A C COST ME.			

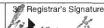
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician August 2007 VICTORIA INIGO BJORK 1500 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye June 15, Birthplace (State or Foreign Country) **Funeral** year) 1940 Puerto Rico Days 1□ M 2ĂF 083-30-4632 Director Usual Residence of Decedent 10b. County 10a, State 10c, City, Town or Location 10d. Inside City Limits 28a-f show Ħ permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Marial Hygiene. Important: If fem Z7 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified. 1 ☐ Yes 2 No Director Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 Contee Road 21085 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐XYes 2☐ No Specify: White 3 ₩ Widowed 4 Divorced Puerto Rican Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Monserrate (NMN) Inigo Monserrate (NMN) Rivera 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8636 Sandy Plains Road, Baltimore, MD Nancy Louise Bjork/Daughter 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 09-01-2007 Perryman, Maryland 4 ☐ Donation 5 ☐ Other (Specify) St. George's Epis. 22. Name and Address of Facility McComas Funeral Home, P.A., 21. Signature of uneral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myelima **Physician** one year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if an cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of iner Exami attending physician at for use as the burial. Due to (or as a consequence of) Physician/Medical as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? 'es 2 No death? 1∐ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient P 1 ☐ Yes 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

97

State 31. Date Registrar

31. Date filed (Month, Day, Year)

06



AN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAHRAN/6025. Atwood Rd, Suite 200 Beldig

		For State Registrar	State of M	Marylan		artment of tificate of			, ,		2007	28460
Physicia /Medic		1. Decedent's Name (First, Middle, Last			Brig	993			2. Date of Dear	Day.	51 2007	3. Time of Death
Examin		4a Facility Name (If not institution, give	1	r)		4b. City, Town	or Location of	of Death	1	4c. (	County of Death	
Funeral Director		227 33 333	ex 7. A	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Yea Months Day		24 Hrs. Min.	8. Date of Birth (Month, Day JUNE 2	5 , 1	9. Birthr 2 VI	place (State or Foreign ntry) RGINIA
yland how at		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
ne Mar 8a-fsl	Director	MD. N/A			BALTI	_						1√Yes 2□No
with the a or 2 to be no	Ë	10e. Street and Number 5616 CLEARSPR	ING RD.			10f. Zip Code	1212		1	-	en of What Coul USA	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 XNever Married 2 Married	12. Was Deceder Armed Forces 1  Yes 2 If Yes, Give	6?		Was Decedent of f Yes, specify Co	f Hispanic Ori uban, <b>M</b> exicar		ecify Yes or No- Rican, etc.)	1	4. Race - Americ Black, White,	etc.
72 hours an atural", ciical Exar	ted by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ec (Specify only highest gra	Year or Dates lucation		16a. Deced	1 ☐ Yes 2 ☐ N dent's Usual Occ	aupation		na I	- 1-	Specify: BLA ad of Business/In	
within within than "I than "I	Completed	Elementary/Secondary (0-12) 12TH	College (1-4o	r 5+)		kind of work dor DO NOT use reti	red)	e or worki	, ig	TTOO	L COMP	7. N.V
e filed al Hygi other vent, t	Be C	17. Father's Name (First, Middle, Last)			ша	DONER	18. Mothe	er's Name	(First, Middle, i			WIAT
y i.a.i	2	STUART BRIGGS			T				RINE CH			
NICAL nd 2 sh nth and 27 is m r traum		19a. Informant's Name/Relationship (*ANDREA BRIGGS			1	-				-	Town, State, Zip	. 21212
ages 1 ar ant of Hea t: If Item y or other		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Conation 5 ☐ Other (Specif		CI	emetery, crer	sition (Name of natory or other p	elace)		8,2007	,	cation - City or To	
rmit. P spartme portan y injur		21. Signature of Funeral Service Licer		/   LA.					FUNER		<u>OW_GRO</u> HOME	VE, PA.
3 88 E E S		Del nadine	1. Acu	ugg	1	412 E.	PRES	TON	ST. BA	LTO		1213
Physician /Medical	v 2	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Accura	line.	40 C	ardia	lying, such as	mof	ar ll	ior	1	Approximate Interval Between Onset and Death
Examiner	_	Sequentially list conditions,	b	as a consequ	<i>V</i>			/			,	/- 2 Nove
cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ								
The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 IØ No 9 □ Unknowy	23c. If yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Fetal	Ideath 3□	Ectopic pregnal				2	3d. Date of deliv	ery Day Year
quires that a signed by all doe deta	þ	Part II. Other significant conditions	ontributing to death	but not resu	ulting in the u	nderlying cause	given in Part I	l.	23e. Did to		se contribute to t	he cause of death?
The law recte has bee sage 2 shot	Completed								24a. Was a autops perfor		24b. Were auto prior to co death? 1 □ Yes	opsy findings available impletion of cause of
clan: ertifica	BeC	25. Was case referred to medical examiner?				T		e of Death	(Check only or	/		77
ding Physician: The	ပ္	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpa		ER/Outpatien	IL 3 DOA		-	me 5 Reside		Other (Speci	fy)
th. : After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, E	Day Year)	Injury	V	ork? ☐Yes 2☐		zou. Describe III	ow injury	Occurred	
all or Atter after dea Director	Certification:	3 Suicide 6 Could not be 4 Homicide determined	Zoe. Flace of I	njury - At ho etc. (Specify	me, farm, str	eet, factory, offic	e		28f. Location (Si City or Town	treet and n, State)	l Number or Run	al Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, p	edical C		nysician: To the besing and manner	of examina								
To th within To th	Me	29b. Signature and title of certifier	Toupe	eial	en	29c. Lice	3060	51	2	29d. Date	e signed/(Month,	Day, Year) 151 2007
<i>y</i>		30. Name and address of person who	completed cause of	death (I)em	23a) (Type,	Print	100	. 1	d - 2	210	239	
Sta	te	31. Date filed (Month, Day, Year)	2007 32. R	ar's Signa	ture	1-0-						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Vear Veronica Champigny 6:30 SEPTEMBER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALTIMORE n/a 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🛛 F Director 214-46-9151 60 12/28/1946 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int. If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits ntal Hygiene. ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at Director MD n/a Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3116 Stafford Street 21223 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🛣 No White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Secretary State Goverment 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be litem 27 is marked r other traumatic e Fredericka Rudulph 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mark Benson Son 1709 Spence Street, Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H
Important: If Ite
any Injury or ot
once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 9/6/2007 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service License 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HNITER disease or condition resulting in death) Five /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or all a consequence of the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 🔀 No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2□ No 1 X Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? Yes 2. No certificate 1□ Yes rector. To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No this 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the I 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician; the Hospital

2

CHAMPICN,

Baltimore, Maryland 21215-0036

State Registrar

31 Date filed (Month, Day, Year) SEP 8 6

rattan

29b. Signature and title of certified

ATHAN

3449

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wickens Avelue

ATTENDING CARDIOLOGIST MARYLAND

29c. License number

00041

Suite

300

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) CAMPER 2007 Physician NAOHI 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BaLTIHORE Examiner Randalls Town CENTER North West Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months 1 M 2 F 85 260.32.4594 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 □ No Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 Bancrost Race - American Indian, Black, White, etc. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ∐Yes 2 ☐ If Yes, Give Year or Dates: 2 No Specify Blach 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ NO Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4or 5+) Domestic Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melissa Jenhs 0055 vivester 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3419 Bancrost Ad Bal timore MO Dor othy T 20a. Method of Disposition Brunson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) en Cemekry 09.08.07 Glennville, GA 22. Name and Address of Facility Vaughn C. Gireen funerue Service talltown Cemekry 21. Signature of Funeral Service Licensee 8728 Liberty Md Mandallotain mo 21133 Green auchn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. vascular Immediate Cause (Final acciden disease or condition resulting in death) of basilar artery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical 23d. Date of delivery IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year 3 Ectopic pregnancy Day 2 Fetal death 5 ☐ Other (specify) 4 Pregnant at time of death 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 X Inpatient 1 ☐ Yes 2 M No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Injury 1 Natural

**Funeral** 

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

death with the Maryland

should be filed within 72 hours after ind Mental Hygiene.

and Mental Hygie Is marked other traumatic event,

permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traun

**Physician** 

/Medical

Examiner

and

physician pe

P.0.

Division or Vital Records,

Hospital or Attending Physician:

To the within

Saltimore, Maryland 21215-0036

Certification: To

burial-tran the esn funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the form

5 Pending investigation 2 Accident 3 Suicide

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Medical

State

Registrar

4 Homicide

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

30. Name and address of

Plouve

2007

D 65843

person who completed cause of death (Item 23a) (Type, Print) 21133

3 Frour, 5401 Old Court Rd, Randallstown, HD 21133 Kafrouri Abdallah

32. Restrar's Signature

31. Date filed (Month, Day, Year) SEP 06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 7007 raic /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore GilChrist 01 Date of Birth (Month, Pay, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) ocial Security Number 6. Sex **Funeral** Months 1 □ M 2 N F 417.23.2310 Usual Residence of Decedent Director is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 No Director Owings mill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be a Stretham Court 21117 4 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1□Yes 2iXNo Baltimore, Maryland 21215-0036 Specify: Black ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) /Secondary (0-12) College (1-4or 5+) Provider hoseward Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) hosa Lasiki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) netta Ellis Strethham court Owings mills mo Laughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Garrison 1 Surial 2 Cremation 3 Removal from State 109.11.2007 Olvings mills, mo 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 18728 Liberty Moad Mandallstin mo 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Shill Intected Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed as the burlal-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, is certificate has been signed by the attending physician director, page 2 should be detached for use as the burla Completed by Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes After this certificate To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 □ Residence 6 □Other (Specify) (\$10,000 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 THomicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Sept. 3, 2007 00061199

State Registrar

31. Date filed (Month, Day, Year) SEP 06 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite 209, Touson

MI

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: this funeral within 24 hours a

Be 2 Certification: Medical

1 Yes 2 No 27. Manner of Death

29b. Signature and title of certifier

29a, Certifier

(Check only

1 Natural 5 Pending investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

224 Suite Towson

31. Date filed (Month, Day, Year) SEP 0 6 2007 . Registrar's Signature

State

Registrar

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PRIVATE DEPTIME CARROLL  ROWARD TRYING CARROLL  ROWARD TRYING CARROLL  ROWARD TRYING CARROLL  ROWARD TRYING CARROLL  ROWARD TRYING CARROLL  ROWARD TRYING CARROLL  ROWARD TRYING CARROLL  ROWARD CARROLL  ROWARD TRYING CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROLL  ROWARD CARROL				For State Registrar		Maryland / D	epartment Certificate				Reg. No	7007	28465
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Physician (Medical Examiner)  23a Part Lifer the disease, or complications that caused the death. Do not enter the mode of origin, such as cardiac or respiratory arrest, inmediate clause (Final Lifer Life Cause)  4 Securitally fel conditions and the completed clause of the death. Do not enter the mode of origin, such as cardiac or respiratory arrest, inmediate clause (Final Lifer Life Cause)  5 Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditions. Securitally fel conditio	_	ges 1 and 2 should of Health and Mile II I I I I I I I I I I I I I I I I I	To	19a. Informant's Name/Relationship  Sherry R. Carrol  20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 [	Type, Print) / Wife	20b. Place of I cemetery	3 A Memo	ory I e of er place)	d Number	or Rural Route Nu Abingdol Date	mber, City	or Town, State,  yland  ocation - City or	21009 Town, State
Physician Middleal Examiner    Physician Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middleal Examiner   Middl	Balti	C		1 Kurs Slig-			McComa: 1317 Co	Address S Fur Okesi	of Facility neral oury	Road, Ab.	.A. ingdo	(1.50) S	Land 21009
9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 10 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 10 Yes 2 No 3 Probably 4 Unknown 25. Was case referred to medical examiner? 10 Yes 2 No 3 Probably 4 Unknown 26. Place of Death (Check only one) 27. Manner of Death 1 Notatural 1 Notatural 1 Notatural 1 Notatural 2 No 2 Pending 1 Nover autopsy findings available prior to completion of cause of death? 10 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? 10 Yes 2 No 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? 10 Yes 2 No 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 10 Yes 2 No 2 No 3 Probably 4 Unknown 24b. 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List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. 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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PERFECTO C. VALAR AD, H.D. 1716 HARPORD Rd. Su. 105 FALLS TON UD 21047	Div	9 2 2 5	dical Certif	29a. Certifier 12 Certifying P	building, hydicians To the be miner: On the basis	etc. (Specify)  ist of my knowledge, s of examination and	death cocurred at	tific time	date and nion, death	City or	Town, Stat	e)	s stated
State  State  31. Date filed (Month, Day, Year)  PERFECTO C: VALAR BO, H.D., 1716 HARFORD Kd., Su., 105 FALLS TON MID 2047  22. Registrar's Signature  Registrar  DED 0 6 2007		To the within To the comp	Me	29b. Signature and Itle of pertification of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Con	C, Vac	Parcy of death (Item 23a) (1	29c. 1 Type, Print)	License r	16 3	89	29d. D.	ate signed (Mon	th, Day, Year)
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death C Month Day **Physician** 2007 /Medical 4a. Facility Name (If not institution, give street and number) County of Death Examiner ItI MERC 7. Age (In yrs. last birthday) If Under Months Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 2 Z Min. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 25a be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ILS.A 21222 346 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Neyer Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 ☑ No Specify Completed by Specify: White 3 Nidowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) umberlandoganvicu Ob. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If Ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State Resedale Gardens 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses -adley-Askton Funeral Home 23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit

3 Ectopic pregnancy

5 ☐ Other (specify)

Physician /Medical **Examiner** 

Baltimore, Maryland 21215-0036

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line.	Approximate Interval Between Onset and Death
Due to (or as a consequence of):  b. Osteonyelits of heel	weeks
costeaathnts	yeas
Due to (or as a consequence of):	

Examiner Physician/Medical Completed by Be Certification: To

been signed by the should be detached

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4□Pregnant at time of death

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

23d. Date of delivery

Day

Year

Month

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 \sum Nursing Home 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred

1 Natural
2 Accident 5 Pending investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 No

29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certi

31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D17118

29d. Date signed (Month, Day, Year) Sept 2,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Newland Rd M.D. 3512

Registrar

Medical

SEP 0 6 2007

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007

		•	For State Registrar	State of Mary		partment of F e <i>rtificate of</i>		wentai Hy	Reg. No.	0 /	28461
		4	Decedent's Name (First, Middle, Last					2. Date of De		Year	3. Time of Death
	Physici /Medic		Mildred J.	Veviu	10_			sept	2,0	2007	1443 PM
	Examin	er	4a. Facility Name (If not institution, give	street and number)	laine	4b. City, Town, o	Location of Death	9	4c. Cour	of Death	aud 1
. 9	Funeral		5. Social Security Number 6. Se	x 7. Age (In	yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	9. Birthp	place (State or Foreign
	Director		062-07-6995	□M 2X0F 93	Yrs.	Months Days	Hours Min.	Month, Da March 2	7, 1914		klyn, NY
	pue M.		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or	Location				1	10d. Inside City Limits
	Maryl-f sho	tor	Maryland Howard		Columbi	а					1 ☐ Yes 2 🖔 No
	h the	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cour	ntry?
	ath wit	raiD	9429 Hickory Limb			2104			U.S.A.		- Ladia
36	s 1 and 2 should be filed within 72 hours after death with the Marylend f Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23a or 28a-f show other traumatic event, the Medical Exertinar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	in U.S. 13	3. Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 21 No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	0- 14. H B	ace - Americ lack, White, cify: Wh	
2-00	r2 hou	ted	15. Decedent's Edu (Specify only highest grad	ication	16a. Dec	cedent's Usual Occup	Dation during most of wor	rkina	16b. Kind of		ndustry
Maryland 21215-0036	within 7 ene. then "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ve kind of work done DO NOT use retire			Munici	-	ri a t
121	filed with Hygiene. other ther		12 17. Father's Name (First, Middle, Last)		Admi	nistrativ	18. Mother's Nar		A		100
land	should be and Mental I smarked o	To Be	George A. Bushey				Mary Fr	ances S	Sheeran		
ary	2 shoul and M ls mar	-	19a. Informant's Name/Relationship (T)	/pe, Print)	19b. Ma	iling Address (Street	and Number or Ru	ıra/ Route Numb	per, City or Tow	m, State, Zij	p Code)
	1 and 2 Health a tem 27 li		Kathleen Devine (			Hickory	Limb, Col		T		0
Baltimore,			20a. Method of Disposition 1 № Burial 2 □ Cremation 3 □ F	Removal from State	cemetery, c	position (Name of rematory or other pla		Date	20c. Locatio		
Itim			4 □ Donation 5 □ Other (Specify, 21. Signature of Fune/al Service Licens			's Cemete:			Middle	; V111	age, NY
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the ne cause on each line.	death. Do not s	onter the mode of dying	ng, such as cardiae	or respiratory a	arrest,		Approximate Interval Between Opset and Death
10	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a con	nsequence of);						1000
5	Examiner		Sequentially list conditions,	6 177	evto	45/04	7				10yxs
1	Sit 9d	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	nsequence of):						
$\sqrt{}$	and and il-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a co	nsequence of):						
68760,	fficate be executed g physicien and as the burial-transit		l	d							
	- D 05	ledicai									
.O. Box	The law requires that the death certif Ite has been signed by the ettending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у			Date of deliv Month	Pery Day Year
<u>α</u>	igned by	by Pr	Part II. Other significant conditions co	/ -	t resulting in the	underlying cause give	ven in Part I.				the cause of death?
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Division of Vital Records,	The law rate has be	Completed						24a. Wa: auto perf 1 🗆 Yes	s an 24 opsy ormed 22 No	b. Were auto prior to co death? 1 \( \sum Yes	opsy findings available ompletion of cause of 2 No
Vita	dector,	Be	25. Was case referred to medical examiner?	Hospital:		Ot	26. Place of Dea				
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ion	nding ath. r: Afte	atior	1∕BNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) Injun		rk? ]Yes 2 □No				
ivis	or Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, pecify)	street, factory, office		28f. Location City or To	(Street and Nu own, State)	mber or Run	al Route Number,
	To the Hospitel or Attending Physicien: The law within 24 hours aftar death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical Ce		rsician: To the best of my							
	thin 2 thin 2 the F	Med	29b. Signature and little of condier /	and manner stated.		29c. Licens	se number		29d. Date sig	ned (Month,	, Day, Year)
	5 7 K 5		· Kan	Mb		194	161 I		Sept	2	2007
Λ			30. Name and address of person who d	ompleted cause of death	(Item 23a) (Typ	e, Print)	/ -			7	
			Cary KARTON ME	10805 His	KOVY	Ridt	Rd C	slus	519 140	121	1644
48.	Sta Registr		31. Date filed (Month, Day, Year)	32. Abgistrar's S	Signature	29c. Licen:					
			357 0 0 2	JUI Party March	00	7					

DHMH 17 Rev 1/2001

07-Tre

n/ ier	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	O. Time of Death							
er			Month [	Day Year							
	Trent M. Earll		September	1, 2007							
	4a. Facility Name (if not institution, give street and number) Universtiy Hospital	4b. City, Town, or Location of Baltimore		4c. County of Death							
	5. Social Security Number 6. Sex 7. Age (In yrs. last		A disc	(MM/DD/YYYY) 9. Birthplace (State or Foreign							
	212-84-6921   1X M 2 F	Months Days Hours	April	27,197 (Country) MD							
ŀ	Usual Residence of Decedent		·	10d. Inside City Limits							
	1001 00010	Fown or Location		1 Yes 2 X No							
ᅵ	MD Baltimore	Middle River	E E								
Director	10e. Street and Number 13119 Miles Road	10f. Zip Code 21220		g. Citizen of What Country? USA							
		3. Was Decedent of Hispanic Origin	n? (Specify Yes or No-	14. Race - American Indian, Black, White, etc.							
al	Never Married 2 Married	If Yes, specify Cuban, Mexican, F	Puerto Rican, etc.)								
ഥ	3 Widowed 4 X Divorced If Yes, Give Year	1 Yes 2 X No specify:		Specify. White							
9	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kil	nd of work done	16b. Kind of Business/Industry							
ete	Elementary/Secondary (0-12) College (1-4 or 5+)		ise remed)								
ם	12th										
	17. Father's Name (First, Middle, Last)	18.Mother's	Name (First, Middle, M	laiden Surname)							
Be	Dennis Earll	Patr	ricia Arn	old							
7											
				more MD 21220  20c. Location - City or Town, State							
	Zoa: Metroe of Bisposition	rematory or other place)		206. Location - City of Town, State							
	Burial 2 X Cremation 3 Removal from State Bay	yview Crematory	9/6/07	Baltimore MD							
	21. ignat of Fundant rvice Lice se	22. Name and Address of Facility	300 Mago	Ave. Balto. MD							
	Volet Vous and h	Connolly Fur									
	23a. Fart I. Enter the riseas , Complications that crused the death.	Do not enter the mode of dying, such as ca	rdiac or respiratory arre	est, shock, or neart Approxima e Interva Between Onset and							
, (	failure. List only one cause on each line.	the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s		Death							
1 27	Introducte Oddoc (1 indi dioddoc										
	Sequentially list conditions, b.										
ЭĒ	if any, leading to immediate Due to (or as a consequence of	):	100								
Ξï	(Disease or injury that initiated	A									
Exa	events resulting in death) Last	<i>y</i> .									
g	V INDENDED V AMENDED #14. DOTH.	G872.10/15/07.WS									
edio		perME, 2872', 10/I1/07 TT		23d. Date of delivery							
Ň			pregnancy	Month Day Year							
ciar	nast 12 months?	2									
ysi	1 Yes 2 No 9 Unknown 9 Unknown										
	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Pa		bacco use contribute to the cause of death?  3 2 No 3 Probably 4 Unknown							
			24a. Was								
ple			autop	prior to completion of cause of med? death?							
E O			1 🗸 Yes								
	25. Was case referred to medical		(Check only one)								
0 B	Innatient 2	ER/Outpatient 3 DOA Other		Residence 6 Other:							
<u>:</u>	27. Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work	? 28d. Describe	how injury occurred							
ion	Natural 5 Pending 3/2/1/1007	8•23 nm 1 Yes 2 X	No sul	bject was shot							
ical	2 Accident Investigation 28e. Place of Injury - At h	ome, farm, street, factory, office building, et	c. 28f. Location (	Street and Number or Rural Route Number, Cit							
irit	determined to the state of		4400 Be	State) lair Rd. Baltimore, MD							
cal Ce	29a, Certifier	ge, death occurred at the time, date and pla	ace, and due to the caus	se(s) and manner as stated.							
edi	and manner stated.			29d. Date signed (Month, Day, Year)							
Σ	29b. Signature and title of certifier			September 5, 2007							
	My w, mp	U.C.IVI.E.		Coptombol o, 2001							
		n 23a)	204								
	Ling Li, MD Assistant Medical Examiner 111		201 								
	Medical Certification: To Be Completed by Physician/Medical Examiner	11. Marital Status   12. Was Decedent Ever in U.S. Armed Forces?   12. Was Decedent Ever in U.S. Armed Forces?   12. Was Decedent Ever in U.S. Armed Forces?   12. Was Decedent Status   1. Never Married   2. Married   1. Was Decedent Status   1. Was Decedent Status   1. Was Decedent Status   1. Was Decedent Status   1. Was Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. Decedent Status   1. 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Was Decedent of Hispanic Origin   14 Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   1   Yes   2 X No   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes	Till Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat Status  IT Meritat							

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 2, 6:30 A M Ruth Philips Ellingsworth 2007 Sept. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Blakehurst Care Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days 1 □ M 2 X F 219-60-9216 90 Feb. 16, 1917 Maryland Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 W. Joppa Road 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Roland Philips Annie Marion Hartman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard P. Ellingsworth/Son 33 Hickory Meadow Road Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery crematory or other place) Druid Ridge Sept. 5, 20a. Method of Disposition 20c. Location - City or Town, State M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Cemetery Baltimore, MD Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 21. Signat **Puneral** Service 痢 W. Clary 23a. Part1. Enter the osease, or coro licatio shock, or heart fedure. List on one caus Immediate Cause (Final disease or condition resulting in death) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death amplications of demention 4 con Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

Director

Funeral

ð

Completed

Be

with the Maryland

death v

filed within 72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me

Maryland 21215-0036

Baltimore,

and burial-trai physician the attending use for has page 2 certificate this After t 24 hours after death e Funeral Director;

Examine Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

58303 September 4 2007

To the Registrar

Hospital or Attending

the

death.

31. Date filed (Month, Day, Year) 0 6 2007 SEP

29b. Signature and title of certifier

rarerus

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AALON J. CHANUES M 6701 N. CHANGS ST TOWSON NO ZIZOY

32. Registrar's Signature

State

07-06809 Kevin Foster

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 28470

			- For State egistrar	Certifica	ate of Death		Reg.	No.	
Phys		n/ 📑	I. Decedent's Name (First, Middle,Last)  Kevin		Foster		2. Date of Death Month D September	)ay Year 2, 2007	3. Time of Death 1058 hrs
			a. Facility Name (if not institution, give street at Johns Hopkins Bayview Medical (		4b. City, Town, Baltimore	or Location of Death		4c. County of Dea	th
Fune	ral		5. Social Security Number 6. Sex	7. Age (In yrs. last birt	hday) If Under 1 Y	ear If Under 24Hrs	. 8. Date of Birth	(MM/DD/YYYY) 9. B	irthplace (State or
Direc			214-98-7920 1 XM 2	F 25	Yrs. Months D	ays Hours Min	11-4-	1981 Fore	country) Md.
	any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
1	3		Md. NA	Ba	ltimore				1 X Yes 2 No
Maryland	at onc	흥누	10e. Street and Number		10f. Zip Code		. 10g	. Citizen of What Co	ountry?
he Ma	23a or 28a-t sno notified at once	Director	3232 Cliftmont Avenu	ie	2121	.3		USA	
with t	ns 23a	— L		Decedent Ever in U.S.	13. Was Decedent of			14. Race - Am White, etc.	erican Indian, Black,
0036 within 72 hours after death with the Maryland jiene.	nust l	Fune	X Never Married 2 Married 1			oan, Mexican, Puerto	Ricall, etc.)	•	
after	iner	ð.	3 Widowed 4 Divorced If Yes, Gi or Dates:		1 Yes 2 X		work done	Specify: B  16b. Kind of Busines	lack
hours	other than "natural", the Medical Examiner		15. Decedent's Education (Specify only highest Elementary/Secondary (0-12)		Decedent's Usual Occu during most of working			TOD. TAILS OF EGSITICS	o/maddity
36 hin 72	dical	ompleted	12th grade	• •	Driver	,*		APS East	Coast, Inc.
5-00 iled witi Hygien	other the Me	하	17. Father's Name (First, Middle, Last)			18.Mother's Nam	e (First, Middle, Ma	aiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene.	event, I	æ	Kevin R.		r, Sr.	Diane		Handy	
		2	19a. Informant's Name/Relationship (Type, Prin Diane L.Foster	Mother 19	b. Mailing Address (Si 3232 Clift				
nd 2	tem 27 is r traumatic	ŀ	20a. Method of Disposition		of Disposition (Name of			20c. Location - City	
- v -	⊑ੂਙ		1 X Burial 2 Cremation 3 Remo	oval from State crema	tory or other place)		-7-07	Dandall	atom Md
Baltimore, permit. Pages 1 a	4 Donation 5 Other Specify: King Mem. Pk. 9-7  21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ma								stown, Md.
Baltimo permit. Page Department o	Impor		A lady Warrer 1101 E. North Ave., Baltimore, Md.						
hysic	ian		23a. Part I. Enter the disease, or complications	that caused the death. Do n	ot enter the mode of dy	ing, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
vledi ≟xami	ical	-	failure. List only one cause on each line.  Immediate Cause (Final disease a. Hangir	ng					Death
Exami	mer		or condition resulting in death)  Due to (0	or as a consequence of):	300				
		5	Sequentially list conditions, if any, leading to immediate b. Due to (c	or, as a consequence of):		•			f 4.
		nin.	cause. Enter Underlying Cause						
ted .	and - transit	Examiner	events resulting in death) Last Due to (	or as a consequence of):					
execu	ian an	Medical	UNPENDED AMEN	DED					
. <b>60,</b>	physician the burial	Mec		f yes, outcome of pregnance	У			23d. Date of deli	
687 ertific		sician/	23b. Was decedent pregnant in the past 12 months?	Live birth Pregnant at time of death	2 Fetal death 5 Other (Specify)	3 Ectopic pregi	nancy	Month	Day Year
SOX leath o	e atter for us	ysic	1 Yes 2 No 9 Unknown g	Unknown	5 Other (Specify)				
t the	ned by the attending detached for use as	Phy	Part II. Other significant conditions contrib	uting to death but not resulti	ng in the underlying cau	ise given in Part I.			to the cause of death?
G. the	signed be de	d by					-		Probably 4 Unknown
<b>rds</b> requi	been	lete					24a. Was a autops	sy prior	e autopsy findings available to completion of cause of
eco he law	ite has	Completed		<u> </u>			perfor 1 Yes	med? deatl 2 ✔ No 1	Yes 2 No
<u> </u>	ieral Director: After this certificate has been signed filled in by the funeral director, page 2 should be det	a l	25. Was case referred to medical		26.F	Place of Death (Chec			
Vita hysici	this co	O B	examiner? 1 Yes 2 No Hospital:	T Impation 2					ther:
of ing P	After	T:TC	4 🗆	(Month Day Year)		Injury at Work?  Yes 2 ✔ No	Subject han	now injury occurred ged self	
Sion Affeind death.	ctor: y the	atic	2 Assistant Investigation Se	ep 2, 2007 10 e. Place of Injury - At home,	19 hrs		28f Location (5	Street and Number o	Rural Route Number, City
Jivis al or A safter	Dire d in b	Certification:	Suicide 6 Could not be	e. Place of injury - At nome,		loc ballating, etc.	or Town, S		
espita hours	unera ly fille		29a. Certifier 4 Continue Physician: To	the best of my knowledge d	leath occurred at the tim	e, date and place, a	nd due to the caus	e(s) and manner as	stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: completely filled in by the	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier (Month, Day, Yea							
T. wit	LOO LOO	Mec	29b. Signature and title of certifier	Inner stated.	29c. Li	cense number		29d. Date signed	(Month, Day, Year)
			LAI	11.1/	_   0	C.M.E.		September 3,	2007
1	Í		30. Name and address of person who complet		1)				
2	•		Jack Titus MD. Deputy Chief	Medical Examiner	111 Penn Street,	Baltimore, MD	21201 —————		
	S	tate	CED [16 7][1]/ A	32. Registrar's Signature	goards				
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17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  19. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Z  20a. Method of Disposition  1   Burial 2   Cermation 3   Removal from State  20a. Method of Disposition  1   Burial 2   Cermation 3   Removal from State  20b. Place of Disposition (Name or cermatory or other place)  20c. Location - City or Town, State, Z  20c. Place of Disposition (Name or cermatory or other place)  20a. Method of Disposition  1   Burial 2   Cermation 3   Removal from State  4   Donation 5   Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Adgress of Facility  22a. Parti. Enter the diseagle, or complications that caused/the/death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failured. List only diseases or condition resulting in death)  23a. Parti. Enter the diseagle, or complications that caused/the/death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  25a. Parti. Enter the diseagle, or complications that caused/the/death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  25a. Parti. Enter the diseagle, or complications that caused/the/death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  25a. Parti. Enter the diseagle, or complications that caused/the/death.  25a. Parti. Enter the diseagle, or complications that caused/the/death.  25a. Parti. Enter the diseagle, or complications that caused/the/death.  25a. Parti. Enter the diseagle, or complications that caused/the/death.  25a. Parti. Enter the diseagle, or complications that caused/the/death.  25b. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25c. Due to (or as a consequence of):	ndustry
17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  19. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Z  20a. Method of Disposition  1   Burial 2   Cermation 3   Removal from State  20a. Method of Disposition  1   Burial 2   Cermation 3   Removal from State  20b. Place of Disposition (Name or cermatory or other place)  20c. Location - City or Town, State, Z  20c. Place of Disposition (Name or cermatory or other place)  20a. Method of Disposition  1   Burial 2   Cermation 3   Removal from State  4   Donation 5   Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Adgress of Facility  22a. Parti. Enter the diseagle, or complications that caused/the/death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failured. List only diseases or condition resulting in death)  23a. Parti. Enter the diseagle, or complications that caused/the/death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  25a. Parti. Enter the diseagle, or complications that caused/the/death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  25a. Parti. Enter the diseagle, or complications that caused/the/death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  25a. Parti. Enter the diseagle, or complications that caused/the/death.  25a. Parti. Enter the diseagle, or complications that caused/the/death.  25a. Parti. Enter the diseagle, or complications that caused/the/death.  25a. Parti. Enter the diseagle, or complications that caused/the/death.  25a. Parti. Enter the diseagle, or complications that caused/the/death.  25b. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25c. Due to (or as a consequence of):	
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Burial 2 (Cremation 3   Removal from State 4   Donation 5   Other (Specify)	21153
Physician /Medical Examiner  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	MD 0 21093
disease or condition resulting in death)    Medical Examiner	Approximate Interval Between Onset and Death
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FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23d. Date of delight of the past 12 months? 1   Yes 2   No 9   Unknown   23d. Date of delight of the past 12 months? 1   Yes 2   No 9   Unknown   23d. Date of delight of the past 12 months? 1   Yes 2   No 9   Unknown   23d. Date of delight of the past 12 months? 1   Yes 2   No 9   Unknown   23d. Date of delight of the past 12 months? 1   Yes 2   No 9   Unknown   23d. Date of delight of the past 12 months? 1   Yes 2   No 9   Unknown   23d. Date of delight of the past 12 months? 1   Yes 2   No 9   Unknown   23d. Date of delight of the past 12 months? 1   Yes 2   No 9   Unknown   Yes 2   No 9   Unknown   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes	very Day Year
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	h, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
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ORIGINAL

_			State of Maryla  1 - State Amend Item 25 per verb., g	nd / Depa <b>871 ,09</b>	artment of Health	aith and M eath			007	28472
Н	Physici	an	Decedent's Name (First, Middle, Last)  TODA TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZETA  TOTAL TIDA ZET	an.			2. Date of De 08-01-		Year	3. Time of Death 9:52 P M
66 m	/Medi		WALTINA DORA FRAZIF  4a. Facility Name (If not institution, give street and number)	SK .	4b. City, Town, or Lo	ocation of Death	00 01		nty of Death	7.52 1
>	Examir	ner	3105 Lakehurst Avenue		District I			1	ce Geo	orge's
- April	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday)	If Under 1 Year II	_	8. Date of Bir (Month, Da	th v, Year)	9. Birthp	lace (State or Foreign
j.	Director		579-76-0949 1□M 2₺F 51	Yrs.	Line Laye		06-23-	1956		, D.C.
	land ow it		Usual Residence of Decedent           10a. State         10b. County         10c. C	ity, Town or Lo	ecation				1	0d. Inside City Limits
	Mary I-f she fied a	ţ	Maryland Prince George's	Distric	t Heights					1 Yes 2 No
	th the or 28g	)irec	10e. Street and Number		10f. Zip Code			10g. Citizen o		ntry?
	23a cust b	ral	3105 Lake Hurst Avenue		20747				S.A.	
920	be filed within 72 hours after death with the Maryland that Hygiene.  dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Yes, Give Year or Dates:		Was Decedent of Hispa If Yes, specify Cuban, 1 □ Yes 2 1 No 8	anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Spec	lace - Americ lack, White, city: B1	etc.
2-0	72 ho natur dical J	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during DO NOT use retired)	on ing most of worki	ng	16b. Kind of	Business/Ind	dustry
121	vithin sne. than "	jd m	Elementary/Secondary (0-12) College (1-4or 5+)	Ch				Privat	e Indi	ıstrv
d 2	filed withii Hygiene. other than ent, the M		4th 17. Father's Name (First, Middle, Last)	Oil		3. Mother's Name	(First, Middle			
lan	lid be lental ked o	To Be	Walter Charles Frazier			Dolori	s Bush			
ary	d 2 should be filed v th and Mental Hygie ?7 is marked other t traumatic event, th	-	19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and					
Σ,	ss 1 and 2: of Health ar item 27 is r other trau		Juanletta Johnson/niece		Lake Hurs					
Baltimore, Maryland 21215-0036			1□Burial 2□Cremation 3□Removal from State 4□Donation 5ৢ∏Other (Specify) in state	cemetery, crei	sition (Name of matory or other place)	1	Date	20c. Location	n - City or To	own, State
Ball	permit. Pag Department Important: I any Injury o		21. Signatura of Funeral Service Licensee  Ronald S. Wade, Directo	r St	2. Name and Address of ate Anatom altimore, M	ny Board D 2120	1.		more S	
	Physician		23a. P. 11. Enter the dist ase, if constitutions that caused the deal ships, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a. Attroscler.					rrest,	1	Approximate Interval Between Onset and Death Unknown
4	/Medical Examiner		Due to (or as a conse	quence of):					1	Unknown
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o,	cate be executed physician and the burial-transit	Exa	resulting in death) Last  Due to (or as a conse	quence of):						
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O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 8 No 9 □ Unknown  23c. If yes, outcome pf pregreation in the past 12 months? 1 □ Yes 2 8 No 9 □ Unknown	tal death 3□	Ectopic pregnancy Other (specify)				Date of delive	ery Day Year
۵	that ined by detail		Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause given i	in Part I.	23e. Did t	obacco use co	ontribute to th	ne cause of death?
rds	w requires been sign should be	ed by	Chronic Renal Disease				10	Yes 2□ No	3 ☐ Prob	ably 44 Unknown
or Vital Records,	The law re te has bee age 2 sho	Completed					24a. Was auto perfo	an 24 osy ormed? 2 No	b. Were auto prior to co-death?	psy findings available mpletion of cause of 2□ No
ita		BeC	25. Was case referred to medical examiner?	- Alp	20	6. Place of Death				
۲V	Physician: r this certific ral director,	10 E	1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatier		4 ☐ Nursing Ho				y)
on c	ing After	ion:	27. Manner of Death 1 名 Natural 5 □ Pending (Month, Day Year)	28b. Time of Injury	Work?	s 2 □ No	28d. Describe	how injury occ	curred	
Division	Atten r deatl ector; by the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At 1 ☐ Duilding, etc. (Spec			28f. Location ( City or To	Street and Nui wn, State)	mber or Rura	al Route Number,	
_	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examinand manner stated.							
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License no	umber		29d. Date sig	ned (Month,	Day, Year)
			Hratel gollen		504	54		4ug	st,	6,07
-			30. Name and address of person who completed cause of death (Ite	m 23a) (Type,	Print)	E+ Was	hinatan	Md	20744	
	CA	10	A. Yazdani, MD 9400 Livingston  31. Date filed (Month, Day, Year) 32_Registrar's Sign		ource 330	rt. was	TIIR COL	, III.		
	Sta Registi	_	SED 0.6 2007		wee					

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear **Physician** Month TIMOTHY GREENE 31 3:15 AM 2007 /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore University of Maryland Medical Center N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1**∑**M 2□F Director 212-82-8451 38 Oct. 2,1968 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits your j ral", or Items 23a or 28a-f shov Examiner must be notified at 1X Yes 2 No Director Maryland Baltimore City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with t Funeral 1240 Carroll Street death v 21230 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event. the "tem" Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify Specify Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) 1 Year Police Officer Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Solomon Greene ပ Shirley Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) Mrs. Maria H. Greene 1240 Carroll Street Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State Druid Ridge Cemetery 9/5/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 21. Signature of Funeral Service Licenses 7922 Wise Ave. Dundalk, Maryland 21222 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardio pulmonary
Due to (or as a consequence of): 8/29/07-8/31/07 /Medical Examiner AORTIC Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an has autopsy performed? certificate Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2[] No 1 🗌 Yes 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After to the funeral price on the funeral price. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 8/31/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vigilance Baltimore, Maryland south Greene Deon 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 06

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEP TEMBER **Physician** 2007 Lillian A. Gately /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. Mar. 11, 1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Manay Land **Funeral** Months 1 □ M 2 🗓 F 212-05-8293 88 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Director 1 ☐ Yes 2 ☑ No notified MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with a or 300 Sunflower Drive 21014 Apt. 315 USA 23a "natural", or items 23a Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No white Specify ģ Specify: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) the Sales Clerk Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur P. Davis Estella M. Wise 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 Is
any injury or other trau 1300 Fordham Court; Bel Air, Jeanne L. Lewis daughter MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 □ Removal from State 5 ☐ Other (Specify) Highview Mem Gardens 19/6/07 Fallston, MD 4 □ Donation 21. Signature of Fun and Service 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of) Examiner URINARY TRACT INFECTION Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last dua to for es a nonsecuence offi-Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physician Physician/Medical as attending p IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2**X** No RENAL INSUFFICIENCY 1 🗌 Yes 3 Probably 4 □Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an ANEMIA page 2 s nas autopsy this certificate 1∐ Yes the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No

27. Manner of Death
1 Natural
2 Accident Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No the Funeral Director: mpletely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) o.

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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State Registrar

SEP 0 6 2007

BOON POH LIM.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.



D37254

TOWSON, MARYLAND 21204

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		•	For State Registrar	State of Marytar	Ю РВЕБЕ Сел	tificate of	lealth and il Death	ମିଟିntal Hyg	giene 2007	28475
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day Year	3. Time of Death
	Physicia /Medic		SANDRA LEE GUL	LION				AUGUST	30, 2007	5:08 P [™]
1	Examin		4a. Fecility Name (If not institution, give	street and number)			r Location of Death	1	4c. County of De	ath
			2107 Fairlane Roa  5. Social Security Number 6. Sec		last hirthday)	Bel Ail	If Under 24 Hrs.	8. Date of Birtl	Harford	irthplace (State or Foreign
и	Funeral		10	M 287 F	3 Yrs.	Months Days	Hours Min.	(Month, Day	v, Year) (	country) aryland
	Director		213-66-8803 Usual Residence of Decedent		0.5			Mar. I	1, 1/34, 12	
	yland now		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Mar.	cto	Maryland Harford	Da	rlingt	on				1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	23a		3328 Dublin Road			21034			USA	nerican Indian,
	er de	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cubi	ispanic Origin? (S an, Mexican, Puerl	o Rican, etc.)	Black, Wi	
36	72 hours after death with the Maryland naturel; or Iteme 23a or 28a-f ehow deat Examinating the codified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
Ş	ture sture		15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busines	
215	within 72 ene. than "na	Completed	(Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of word)	King		
212	e filed within al Hygiene. I other than vent, ir a Ma	E	12		Medic	al Recept			Private H	ealthcare
힏	be filed within 72 hours after death with the Marylan ital Hygliene. Ed other than "naturel", or Iteme 23a or 28a-f show other than "naturel", or Iteme 23a or 28a-f show it it a Madical Examinat man be collined at	Be (	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
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Maryland 21215-0036	V 42 = 2		19a. Informant's Name/Relationship (T) Gary Gullion / Hus						er, City or Town, State on, Maryla	
di.	s 1 and 2 f Health Item 27 other tr		20a. Method of Disposition	206.	Place of Dispo	osition (Name of		Date	20c. Location - City	
و	if it		1 Surial 2 □ Cremation 3 □ F	Removal from State	cemetery, cre	matory or other pla e Bapt. (		3-07	Colora, M	arvland
Baltimore,	permit. Pag Depertment Important: I any injury o		4 ☐Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens				WIL • ;			arytana
Ba	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		1 Russ (lig		<u>M</u> 1	2. Name and Addre ICCOMAS FI 317 Cokes	ineral Ho sbury Roa	ome, P.A. ad. Abin	don, Mary	land 21009
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the dea						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		DATE	RY FI	MIRR	COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON COMMON CO		Onset and Death
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	P #	iner	if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to (or as a conse	quence of):					
	and and	Examin	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):					
8760,	cate be executed physicien and the burial-transit	alE								
687	ficate physics the	edical		d						
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		75-tania araanaa			23d. Date of	
-	death e atte	Cla	in the past 12 months?	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		□Ectopic pregnand □ Other <i>(specify)</i> _			Month	Day Year
P.0	that the de led by the a detached f	ty y	9 □ Unknown	9□ Unknown						
	The law requires that the death certificate has been signed by the attending loage 2 should be detached for use as	by P	Part II. Other significant conditions co	ntributing to death but not re	sulting in the t	inderlying cause gr	ven in Part I.		4.0	e to the cause of death?  Probably 4 □Unknown
Records,	w requir been si should									
e C	has be	Completed						24a. Was	an 24b. Were prior prior death	autopsy findings available to completion of cause of
E H		ပ္ပ						1 ☐ Yes	2 XNo 1 1	es 2□ No
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0:		ath (Check only o		Nothonla
<del>f</del> o	S 20	2	1 ☐ Yes 2 🔼 No 27. Manner of Death	28a. Date of Injury	_ ER/Outpatie 28b. Time (					Residence
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27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury 28b. Time of Death 1 Now Accident 3 Suicide 4 Homicide 28b. Date of Injury 28b. Time of Death 1 Now Accident 3 Suicide 4 Homicide 28b. Place of Injury - At home, farm, street, factory, office 28c. Injury at Work? Month, Day Year) 28b. Time of Death 1 Now Accident 28b. Time of Death 1 Now Accident 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day										
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	cal (	29a. Certifier  (Check only 2 Medical Exam	rsician: To the best of my kr	nowledge, dea	th occurred at the to	ime, date and place	e, and due to the urred at the time	cause(s) and manner date and place, and	r as stated. due to the cause(s)
	the H in 24 the F	Medical	one)	and manner stated.		20- Li			:IOd Date signed /M	onth Day Year
	To To	2	29b. Signature and title of certifier	o. The feel	i. de	Sac. Ficeu	se number		21 AA	10 200 4
	11				14		· e s e /		of I pru	9004
1	2		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type	103 Fu	1 kli	Source	Dr Bas	6, 2007 chame, MD
	C+	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	1-5/10	ν(Λ ¹ ¹ ¹	1		, ,
	Regist		CED O 6 200	1.00	· ka	280		•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28476 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 5 9007 **Physician** 1.25 AM Geraldine Virginia Galuska /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE DARHMIGTON MERULL BURNUE AKUNUSE BACTIMORE enter If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In vrs. last birthday Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Director 212-30-5629 ΜD 05-15-1934 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 873 S. Shore Drive 21060 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1□Yes 2 No Specify: White 3 XVidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Glen Curtis ၉ Virginia Catherine Keiffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Virginia Pumphrey/Daughter 303 Dogwood Road Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Cremation 4 Donation 5 Other (Specify) 09-05-2007 Stevensville, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee 1 2nd Ave SW Glen Burnie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one complete the death ine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) HEUMATON /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter cricerying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a Division or Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 certificate has irector, page 2 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Yes 2 No s after death.

I Director: A
od in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft To the Funeral DI completely filled ir the Hospital 12 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Yely)
SEP 0 6 2007

and address of person



ho completed cause of death (Item 23a) (Type, Print)

mile

			1 - State Registrar	Ctate of Marylan		rtificate of			Reg. No. 200	7 28477
	Physic	ian	1. Decedent's Name (First, Middle, Last)  Elaine F. Hav					2. Date of Dea Month	Day Yea	3. Time of Death
	/Medi		4a. Facility Name (If not institution, give s			4h City Town o	or Location of Death	Sept.	1 2007 4c. County of De	7:58p M
E.	Exami	iler	1213 3rd Avenue	·			dle Rive	er	Baltin	
	Funeral Director		213-07-0070	7. Age (In yrs. 1	,,	If Under 1 Year Months Days				irthplace (State or Foreign Country) aryland
	and and t		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	he Mary 18a-f sho otiffed a	Director	MD Baltimo	ore	MI	ddle Ri	ver			1 □Yes 2 No
	th with the 23a or 2	al Dire	1213 3rd Avenue	e		10f. Zip Code	220		10g. Citizen of What (	Country?
9800	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 77 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	d by Funeral	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates:		1 □ Yes 2 □ <b>XN</b> o	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wi Specify: Wh	
21215-0036	within 72 liene. iene. • than "nat	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th	cation completed) College (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done DO NOT use retired AGEMENT	oation during most of worki d)	ng	U.S.Gove	
pq	e filed Il Hyg other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Surname)	
Maryland	I 2 should be filed w h and Mental Hygie 7 Is marked other t raumatic event, th	10 B	John Smitzer				Elizab	eth Di	.eter	
lar	2 sho and I Is ma	ľ	19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street	and Number or Rura	I Route Numbe	er, City or Town, State	, Zip Code)
6,≥	s 1 and 2 f Health item 27		Patricia Callis							
Baltimore,	t. Pages tment of tant; If it ijury or c		20a. Method of Disposition  1 □ Surial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)  21. Sign Ture of Fine at Section 1 section 1.	emoval from State Par	emetery, cren CKWOO		ery 9/6/		20c. Location - City of Baltimor	e MD
Ba	permi Depar Impo any Ir once		21. Significate of extra significant services	mell		. Name and Addre	30	0 Mace	Avenue	Balto. MD
e U	Physician	W 1	23a. Part Lenter the disease, Scamplic shock, or heart failure. List only one Immediate Cause (Final disease or condition		. Do not ente	er the mode of dyir	ng, such as cardiac o	r respiratory ari	e of Esse rest,	X 21221  Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence CANCEN	ence of):	41 1170	The ID			3 Monus
N		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of).	WICAL	SOPAA	345		Smonth
Ž.	rtificate be executed og physician and as the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					
68760,	cate be ohysicial the buri	Medical I	d.							
P.O. Box 6	death ce attendir d for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	c. If yes, outcome pf pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of d Month	elivery Day Year
	requires that the de een signed by the a nould be detached i	by	Part II. Other significant conditions control  TyspHAcos B	ributing to death but not resu	Iting in the un	derlying cause giv	en in Part I.	23e. Did to		to the cause of death?  Probably 4 Unknown
or Vital Records,	e law has b je 2 sk	Completed	PARAMISIS A	LIGHT VOLA	r Fo	20		24a. Was a autops perform	sy prior to med? death?	
/ita	slcian: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Death			s 2 No
ار ا	Physician; r this certific ral director,	၉	1 ☐ Yes 2 No Ho	ospital: 1   Inpatient 2   E			4 Linursing Hon	ne 5 Reside	ence 6 □Other (Sp	ecify)
S L	After After funera	ion:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Worl		8d. Describe ho	ow injury occurred	
Division	I or Attending after death. Director; Afte I in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hor building, etc. (Specify,	me, farm, stre		Yes 2 No	8f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral directors.	Medical C	29a. Certifier (Check only one)  1 Certifying Physic 2 Medical Examine	cian: To the best of my know er: On the basis of examinati and manner stated.	vledge, death on and/or inv	occurred at the tin estigation, in my o	ne, date and place, a pinion, death occurre	and due to the c	ause(s) and manner a late and place, and du	as stated. ue to the cause(s)
	To th withir To th comp	Ž	29b. Signature and title of certifier	2		29c. License	number	2	9d. Date signed (Mor	nth, Day, Year)
			or notuen	des MA		D2813	3		Sent 5	120007
	V		30. Name and address of person who comes 6569 NC	npleted cause of death (Item.  1440 5  32. Registrar's Signate  2007	23a) (Type, F	BARTIME	sue uv.	1 W20 !	_	
-	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 6	32. Registrar's Signatu	ure A	Sparks				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-06723 2007 28478 State of Maryland / Department of Health and Mental Hygiene Queen Hester Howard Certificate of Death 1- For State Registrar 3. Time of Death 2. Date of Death cedent's Name (First, Middle,Last) Physician/ Month Day August 30, 2007 0005 hrs ¬I Examiner ucen Esther 4b. City, Town, or Location of Death 4c. County of Death acility Name (if not institution, give street and number) Baltimore 3329 West Caton Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Davs Hours Min Director 2 K F M Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County Yes 2 e notified at once. timore Director 10g. Citizen of What Country 10f. Zip Code 10e, Street and Number 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes of No-12. Was Decedent Ever in U.S Armed Forces? Funeral 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married Yes <u>-</u> Give Year No specify. 4 Divorced within 72 hours after Widowed traumatic event, the Medical Examiner 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) pernit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'injury or other traumatic event, the Medical more, MD 21215-0036
Pages 1 and 2 should be filed within 72
nent of Health and Mental Hygiene. Assistant 18.Mother's Name (First, Middle, Maiden Sername) 17. Father's Name (First, Middle, Last) .Davis Be 0 (Street and Number of Rural Route Number, City or Town, State, Zip Code) ဥ 19a. Informant's Name/Relationship (Type, Print) W. Caton 14more 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, Method of Disposition Baltimore, crematory or other place) Burial 2 Cremation 3 Removal from State altimore Donation 5 Other Specify Vaugin C Gircene Junesail 22. Name and Address of Facility 21. Signature of Funeral Service Licenses aughn Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Between Onset and failure. List only one cause on each line ledical Hypertensive cardiovascular disease Immediate Cause (Final disease ∡aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X UNPENDED X AMENDED ME, g871, 9/6/07 TT / #23a,27, perME,g871,9/19/07 TT attending physician or use as the burial The law requires that the death certificate be Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year Month Day Live hirth Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 ✓ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. Yes 2 No 3 Probably 4 V Unknown ۾ Completed 24a. Was an 24b. Were autopsy findings available certificate has been a prior to completion of cause of performed? ✓ Yes 2 No death? 1 V Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medica Division of Vital Be Other 4 examiner? Hospital: Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 this 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Medical Certification: 1 X Natural Yes 2 No 1 Director: Pending within 24 hours after death.

To the Funeral Director: 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie September 1, 2007 O.C.M.E. 9 30. Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Jack Titus MD. 32 Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

07-06803

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

2007 28479

nonda Howard	1- For State Certificate of Death	Reg. No.
Physician/ ledical Examiner	1. Decedents Name (First, Middle Last)	2. Date of Death Month Day September 2, 2007  3. Time of Death 0245 hrs
	4a. Facility Name (if not institution, give street and number)  Mercy Medical Center  4b. City, Town, or Location Baltimore	on of Death 4c. Couply of Death
Funeral Director	WIG-18-49 1 M 2 F 47 Yrs. Months Days Hou	nder 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
·land -f show any once.	Usual Residence of Decedent  10a. Stale 10b. County 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Townyo Location 10c. etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg., Etg	10d. Inside City Lim  1 Yes 2
with the Mary s. 23a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or	1412 Eden St. 21213	4.5.A.
ufer death with the Maryland II", or items 23a or 23a-fsh ner must be notified at once y Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Specify Cuban, Mexic 1 Yes 2 No 1 Yes 2 No specify Cuban, Mexic 1 Yes 2 No specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic 1 Yes, Specify Cuban, Mexic	ran, Puerto Rican, etc.) White, etc.
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Intern 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Ex miner must be notified at once.  To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)	
21215-0036 21215-0036 build be filed within 7 Mental Hygiene, marked other than ite event, the Medical To Be Comple	17. Father's Name (First, Middle, Lass) 30000	hers Name (First, Middle) Maiden Surname) HOWARD
and 2 should leatth and Mer ten 27 is man traumatic ev	19a. Informant's Name/Relationship (Type Print)  19b. Mailing Address (Street and New Local Street and New Local S	ENSt. BAHO, Ma. 2/2
Baltimore, MD 21215-00 permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Mt To Be Con	Burial 2 Cremation 3 Removal from State dematory or other place)  4 Donation 5 Other Specify:  21 Signature of Funeral Service Ligensee	9-7-07 DANUGOUN M
M ឱ្យ ! : : : : : : : : : : : : : : : : : :	23a. Hart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a failure. List only one cause on each line.	as cardiac or respiratory arrest, shock, or heart Approximate Interest Between Onset a
'Medical caminer	Immediate Cause (Final disease or condition resulting in death)  Acute Pontine Hemorrhage  Due to (or as a consequence of):	Death
niner.	Sequentially list conditions, b. if any, leading to immediate cause. Enter Underlying Cause  C.  C.	
cuted of transit	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.	
Division of Vital Records, P.O. Box 68760, within 24 hours after details. The the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transit edical Certification: To Be Completed by Physician/Medical Ex	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	MEO G-872 10/18/07 reh  23d. Date of delivery  Month Day Year
O, Bo nat the dear deby the are etached for y Phys	1Yes 2No 9  ☑ Unknown gUnknown  Part II. Other significant conditions contributing to death but not resulting in the undertying cause given in	
Records, P.C. The law requires that freate has been signed page 2 should be deter Completed by	Hypertension	24a. Was an autopsy performed? 24b. Were autopsy findings avail prior to completion of cause death?
tal Recition: The certificate rector, page	25. Was case referred to medical 20.Frace of Dec	1 ✓ Yes 2 No 1 ✓ Yes 2 No ath (Check only one)
Division of Vital Records. To the Hospital or Attending Physician: The law requivitin 24 hours after death. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should ledical Certification: To Be Complete.	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at W	
Division or Attending vithin 24 hours after death. To the Funeral Director: Aft completely filled in by the fune funded Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building (Specify)	or Town, State)
To the Host within 24 hc To the Fun completely i	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	h occurred at the time, date and place, and due to the cause(s)
D F % F 8	29b. Signature and title of certifier  O.C.M.E.	29d. Date signed (Month, Day, Year) September 2, 2007
Ø	30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201
State Registra		
DHMH 17 Rev 1/2001	OCME GRIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month SEPTEMBER 3, JAMES EDWARD HULL 2007 9:44 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 15xM 2□F **Director** July 9, 1932 207**-**24-5600 Pennsylvania Usual Residence of Decedent a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Marvland | Harford Edgewood 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? items 23a than "natural", or items 23a he Medical Examiner must 21040 614 Aspen Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No δ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Inspector <u>Civil</u> Service permit. Pages 1 and 2 should be filed I Department of Health and Mental Hygis Important: If Item 27 Is marked other any Injury or other traumatic event, <u>tt</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Phillip Hull Mildred Violet Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Hull / Wife 614 Aspen Lane, Edgewood, Maryland 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ⊠ Buírjal 2 ⊡ Cremyitjon 3 DRemoval from Garrison Forest Vet. Cem. 9-11-07 Owings Mills, Maryland onation 5 🗆 Other (Specify) 4 🗆 🛭 McComas Funeral Home, P.A. 21. Sign ure of Funeral Privil Live seg 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sub dura **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading of immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) burial-tran Due to (or as a consequence of): パム/ フオMES MXCOOO のU DI DI DIVISION or Vital Records, P.O. Box 68760 Physician/Medical attending properties for use as 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has death? 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No 2 ER/Outpatient 3 DOA Certification: To funeral Date of Injury (Month) Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 2/07 Accident A 1 ☐ Yes 2 📈 No FOUND AT FOOT OF BED within 24 hours a' er death Fo the Funeral Director: 6 Could not be determined 28e Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ENGEWOOD, Md 614 ASPENLN HOME 29a. Certifier
(Check only one)

2 | Medical Examiner: On the basis of examination and/or investigation, in motion and occurred at the time, date and place, and due to the cause(s) and manner as stated.

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2 | Medical Examiner: On the basis of examination and/or investigation, in motion and occurred at the time, date and place, and due to the cause(s) and document and the cause (s) and document and document and docu D60768 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upperchesapeake Dr., Belair, MD 21014 Tokkadar, MD Muhammad

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2007 28481 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Eva Anna Joram 30, 12:13 PM August 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Charlestown Retirement Community Catonsville Baltimore If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 215-07-1115 1915 Director Jun. Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 715 Maiden Choice Lane Apt. PV 506 death v 21228 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or itel 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be William Charles Luckan Anna Grebner ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health an
Important: If Item 27 is
any Injury or other trau
once. Charles Joram, Jr. - Son 2203 Sunset Dr., Eldersburg, MD 21784 0b. Place of Disposition (Name of Disposition (Name of Nest Arundel 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 □ Removal from State 4 □ Ponation 5 □ Other (Specify) Crematory 8.
22. Name an Address of Facility 8-31-2007 | Odenton, MD Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 1- Natural 5 ☐ Pending investigation after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a *Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, )

8/30/07

Douce Lan, Cafonserule 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a (den ranga 31. Date filed (Month, Day, Year) State 06 2007 Registrar

		,	for State Registrar	State of M	aryland		artment of I tificate of				2007	28482
Sr.	Physici	an	Decedent's Name (First, Middl						Date of De Month	Day	Year	3. Time of Death
	/Media	cal	DONALD		EWE		41 07 7		SEPTER			16:22 PM
	Examir Funeral Director	er	4a. Facility Name (If not institution  TOTALS HOPKINS  5. Social Security Number  216-50-9476	BAYVIEWMED	e (in yrs. la	ENTEK ast birthday) 8 Yrs.		If Under 24 Hours Mi	rs. 8. Date of Bi n. (Month, Di	rth ay, Year)	Coun	
			Usual Residence of Decedent						12-09	<del>-</del> 1948		MD
	nyland how		10a. State 10b. County		10c. City.	, Town or Lo	cation				1	Od. Inside City Limits
	e Ma Sa-f s	Director		Arundel	Li	inthic	um					1 ☐ Yes 2√ No
	vith th		10e. Street and Number				10f. Zip Code			10g. Citize	en of What Coun	try?
	eath v	eral	717 E. Maple	Road 12. Was Decedent	Ever in 11 9	3 112 1	21090	dianania Origina	(Chaoibi Van ar N	U	S.A. 4. Race - America	an Indian
326	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show faumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☒ Divorced	Armed Forces?		- 1	f Yes, specify Cub 1 ☐ Yes 2 XNo		(Specify Yes or No erto Rican, etc.)		Black, White, of Specify: White	etc.
21215-0036	72 hou natura Ical E	ted	15. Deceden	it's Education st grade completed)		16a. Deced	lent's Usual Occu kind of work done	pation	orking.	16b. Kind	d of Business/Inc	dustry
7	ithin 7 ie. ian "r	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	DO NOT use retire	during most of w	iorking	Na	tional S	Security
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Maryland	be fill ad oth even	Be	17. Father's Name (First, Middle,	•					ame (First, Middle		Surname)	
ž	hould d Mer marke	ဥ	Donald Alber  19a. Informant's Name/Relations		•	10b Mailin	ng Addross (Stron		<u>la Ziepo</u> Rural Route Numl		Town Ctate Zie	Codel
<u>S</u>	id 2 sl th an th an traur		Mr. Michael T.				Aldorth				, , , , , , ,	Code)
ā,	f Hea f Hea item	1	20a. Method of Disposition		20b. Pl	ace of Dispo	sition /Name of	1	Date		D 21222 ation - City or To	wn, State
Ë	Pages ent of nt: If i		1 🖄 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S				natory or other pla L1 Cemete		07-2007	Bro	oklyn, M	ſD
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service		Moi	22	Name and Address	ess of FacilitySi	ngleton : Glen Bur	Funera Tunera	al & Cre	emation
r			23a. Part1. Exter the disease, or shock, or heart failure. List	complications that caused							2100	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a. R	ESPI	RATO	RY FA					Onset and Death
Examiner 14 V P O > 1 A												
	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as								4
	ecuter nd transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			MONIN	4					
8/60,	icate be executed physician and s the burial-transit	edical Ex	resulting in death, Last	Due to (or as	a consequ	ence of):						
Q	rtificat ng phy as th	<b>Nedi</b>	IS SSMALE.	1								
.C. Box	w requires that the death certif been signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   1 □ Yes 2 □ No   9 □ Unknown   2 □ Unknown   2 □ Vestal death   3 □ Ectopic pregnancy   4 □ Pregnant at time of death   5 □ Other (specify)   9 □ Unknown   5 □ Other (specify)   9 □ Unknown   5 □ Other (specify)   9 □ Unknown   5 □ Other (specify)   9 □ Unknown   5 □ Other (specify)   9 □ Unknown   5 □ Other (specify)   9 □ Unknown   5 □ Other (specify)   9 □ Unknown   5 □ Other (specify)   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □ Unknown   9 □							23d. Date of delivery Month Day		
cords, P.	uires that i signed by Id be deta	by	Part II. Other significant condition	ons contributing to death b	ut not resul	Iting in the ur	nderlying cause gi	ven in Part I.				ne cause of death?
Leco	hysician: The law rec his certificate has beer I director, page 2 shou	Completed							24a. Was		24b. Were autoprior to condeath?	psy findings available mpletion of cause of
VITAI	un: T tificate or, pa		25. Was case referred to medica	<u> </u>				26 Place of D	1  Yes eath (Check only	2 <b>™</b> No	1 ☐ Yes	2□ No
	Physician: this certificatal director, I	To Be	examiner? 1 ☐ Yes 2 ☑ No	7.0	ent 2∏E	R/Outpatien	t 3 TI DOA Oti	oer.	Home 5 □ Res		Other (Specifi	4
on or	ding Phys n. After this funeral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date of Inju (Month, Da	ıry	28b. Time of Injury	28c. Inju Wo		28d. Describe			<u>//</u>
UIVISION	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	2 Accident Investig	not be 28e. Place of ini	ury - At hor c. (Specify,	me, farm, stre	eet, factory, office		28f. Location ( City or To	(Street and wn, State)	Number or Rura	l Route Number,
	ie Hospita 24 hours ie Funera iletely fille	Medical C	29a. Certifier 1 Certifyir (Check only one) 1 Medicel	ng Physician: To the best Examiner: On the basis of and manner st	f examinati	vledge, death ion and/or inv	occurred at the t vestigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time	cause(s) a	and manner as st place, and due to	tated. the cause(s)
	To th within To th	Me	29b. Signature and title of certifie	101			29c. Licen:	_			signed (Month,	Day, Year)
}			> Theresa	Clowe D.	<b>)</b> .		RES	5-000		91	4107	
	8		30. Name and address of person		leath (Item		•					
	1		THERESA A.		49	40 E	ASTERN	AVENUE	BALTI	more	E, MA Z	1224
	Sta Registr		31. Date filed (Month, Day, Year)	20	ar s Signati	ure Assault	23					
			SEP 0.5 7	HIII IN SECTION	5.5	AND THE RESERVE	atter.					

			For State	State of Maryl		artment of H <i>rtificate of</i>		Mental Hy	giene Reg. No 200	7 28483
			RegIstrar  1. Decedent's Name (First, Middle, Last)			inioate or	Douth	2. Date of De	eath	3. Time of Death
	Physici /Medi		Mary		Knox	1			30 2007	4:55p M
	Examir	er	4a. Facility Name (If not institution, give s 308 Mason Court	street and number)			r Location of Death Limore	1	4c. County of NA	Death
	Funeral	1,01	5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	th 9	. Birthplace (State or Foreign
١.	Director		213-38-4082	]м 2 <b>Х</b> ] F 69	9 Yrs.	Months Days	Hours Min.		5–1937	Md.
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c	. City, Town or Lo	ocation				10d. Inside City Limits
	a-f sh	ctor	Md. N	A	Balt	imore				1 X Yes 2 □ No
	vith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	eath v	Funeral	308 Mason Court	12. Was Decedent Ever i	in U.S. 13.	2123		necify Yes or No		SA American Indian,
980	72 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examiner must be notified at	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 🟋 No	dispanic Origin? (S) an, Mexican, Puert Specify:	o Rican, etc.)	Black,	White, etc. Black
21215-0036	C 3 00	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	ı (Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor.	king	16b. Kind of Busin	ness/Industry
	e filed withii Il Hygiene. other than rent, the M		12th grade 17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·		Central S	terilal	Processe	or J.H.H. , Maiden Surname)	-
land	Ø € 5 €	To Be	17.1 alifet 3 Name (First, Middle, Last)				Pearl	ie (First, Middle	, waiden sunianie) Sewe	ell
Maryland	and s m	F	19a. Informant's Name/Relationship (Type	pe. Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numb	er, City or Town, Sta	ate, Zip Code)
	s 1 and 2 if Health Item 27 i		Rebecca Knox	Daughter	308 b. Place of Dispo	Mason Co	ourt , Ba	ltimore		
Baltimore,	Pages nent of int: If It iny or o		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	1	cemetery, crei	matory or other pla	^{ce)} 9–6	Date -07	20c. Location - Cit	•
Bal	permit. Departr Importa any Inju		21. Signature of Funeral Service License	Wane	22	2. Name and Addre	ss of Facility North Ave	March E	.H. East imore, Md	. 21202
Ą			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ne cause on each line.			ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a con	<u>-</u>	NCER				5 YEAKS
	Examiner		0	Due to (or as a con	sequence oi).					
	pe sit	iner	Sequentially list conditions, if any, leading to immediate sause. Enter Underwing Cause (Disease or injury	Due to (or as a con	sequence of):					
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
68760,	te be e ysiciar ie buri	edical E		l						
	ertifica ing phr e as th	Medi	IF FEMALE:							
O. Box	The law requires that the death certificate be executed te has been signed by the attending physician and sage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ■ No 9 □ Unknown	3c. If yes, outcome pf pre 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	Fetal death 3 □	Ectopic pregnancy Other (specify)	<i>y</i>		23d. Date o Month	*
, P.O	s that the de ned by the a e detached i	by Ph	Part II. Other significant conditions cor	ntributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did 1	obacco use contribu	ute to the cause of death?
ords	w requires been sign should be							1 🗆	Yes 2□No 3[	☐ Probably 4 X Unknown
Division or Vital Records,	The law rate has be page 2 sh	Completed						24a. Was auto perfo 1□ Yes	psy prio prmed? dea	re autopsy findings available or to completion of cause of tth? ]Yes 2 ☐ No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		104	26. Place of Dea			
o	Phys r this ral dir	은 그	1 ☐ Yes 2 No	1 ☐ Inpatient :	2 ER/Outpatien		4 Linursing n		dence 6 Other (	(Specify)
27. Manner of Death  1 Matural  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?  1 Month, Day Year)  28d. Describ								,.,		
Divis	al or Attend s after death al Director: ,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - A building, etc. (Sp.	At home, farm, streecify)	eet, factory, office		28f. Location ( City or To		or Rural Route Number,
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical (	29a. Certifier (Check only one) 1 ★ Certifying Phys	sician: To the best of my ner: On the basis of exar and manner stated.	knowledge, deatl nination and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and mann date and place, and	er as stated. d due to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	MD		29c. Licens	e number +3°134		29d. Date signed (A) 9   4   2	
	· or		30. Name and address of person who co		Item 23a) (Tyne	Drint)				.00 1
4	f ,		DWIGHT IM, M	D 227	ST. P.	AUL PL	ACE, B	ALTIM	ORE MO	21202
7	Sta Registr		31. Date filed (Month, Day, Year) <b>SEP 0 6</b> 2007	Registrar's S	ignature dos	E)				

07-06766 John Wesley Kelly

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John Wesley Kelly	State of Maryland / Department 1- For State Registrar  Certificate		vgiene 2007 2848
Physician Medical Examine	John Wooles	72 - 1 1	2. Date of Death Month Day August 31, 2007  3. Time of Death 1157 hrs
4	4a. Facility Name (if not institution, give street and number) 300 Blk. McCulloh	4b. City, Town, or Location of Death Baltimore City	4c. County of Death
Funeral Director		If Under 1 Year If Under 24Hrs Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
Maryland 28a-f show any Latince.	Usual Residence of Decedent   10a. State		10d. Inside City Limits 1 X Yes 2 No
with the Maryland is 23a or 28a-f she untilied at anor	10e. Street and Number 8217 Bon Air Road	10f. Zip Code 21234	10g. Citizen of What Country?  USA
after death  al", or item iner must b	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced of Yes, Give Year X	Vas Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerto  Yes 2 No specify:	ecify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify:  Black
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Be Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12th grade  2 years  U  17. Father's Name (First, Middle, Last)	ent's Usual Occupation (Give kind of w most of working life. DO NOT use retir	
21215- ould be filed d Mental Hy s marked by tic event, the	Wesley Kelly	Lois I	(First, Middle, Maiden Surname)  auderdale  ural Route Number, City or Town, State, Zip Code)
ore, MD ges I and 2 shr t of Health and : If item 27 is	Ebony Kelly-Daughter 821  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State crematory or	7 Bon Air Road osition (Name of cemetery, other place)	Baltimore, MD 21234 Date 20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Her Important: If ite	21. Sharkure of Funeral Service Licensee 22	emorial Park 9- Name and Address of Facility  4300 Wabash	March F/H West Avenue Balto, MD 21215
Physician /Medical ˈxaminer	23a Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	the mode of dying, such as cardiac or	respiratory arrest, shock, or heart Approximate Interval Between Onset and Death
red nsit <b>Examiner</b>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		,
	events resulting in death) Last  Due to (or as a consequence of):  d.		
68760, certificate be executed nding physician and sea as the burial - transise as the burial - transisian/Medical E.	X UNPENDED #23a, PII, 27, 28a-f, per #25a, PII, 27, 28a-f, per 23c. If yes, outcome of pregnancy	ME,g872, 10/2/07 TT	23d. Date of delivery
	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fregnant at time of death 5 g Unknown	Fetal death 3 Ectopic pregnar Other (Specify)	
P.C es that igned be deta	Part II. Other significant conditions contributing to death but not resulting in the Cocaine use	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
	OF Was and of the station		24a. Was an autopsy findings available prior to completion of cause of death?  1 Ves 2 No 1 Ves 2 No
Vital Rec nysician: The this certificate I director, page	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatien	26.Place of Death (Check on the state of Doah Other Nursing	nly one) Home 5 Residence 6 ✔ Other: Scene
ion of Vi tending Physi eath. for: After this the funeral dir attion: To	27. Manner of Death  1 Natural 5 Pending (Month, Day, Year)  2 Accident Investigation Fnd 8/31/2007 FNd 11		28d. Describe how injury occurred unk
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director edical Certification: To Be (	3 Suicide 6 X Could not be determined (Specify) Found: in parket	eet, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 300 blk. of McCulloh Baltimore, MD
To the Hospital within 24 hours. To the Funeral completely filled	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurrence) 2 Medical Examiner: On the basis of examination and/or investig and manner stated.  29b. Signature and title of certifier	ation, in my opinion, death occurred at	the time, date and place, and due to the cause(s)
O T	Mayona Ine Yvell	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) September 1, 2007
orperd		Penn Street, Baltimore, MD 2	1201
State Registrar	31. Date filed (Month, Day, Year)  SEP 0.6. 2007	(inter	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician ept. /Medical Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Malcolm ockersville 8. Date of Birth Month, Day, Ye. 7. Age (In yrs. last birthday)
Yrs. if Under 1 Year | if Under 24 Hrs. 6. Sex **Funeral** Months 1 □ M 20 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City. Town or Location 10d. Inside City Limits Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at ockeysvill 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? lalcolm 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 20 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 4 ☐ Divorced 3 Widowed Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Makei OWA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Şurname) ပ 19b. Mailing Address (Street and Number or Ryral Floute Nymber, City or Town, State, Zip Code) Phoenix, Son al cum Rd. epti 2007 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) injury or Rossville, Maryland 21. Signature of Funeral Service Licensee natives Funeral + Cremation CH eaceful 2325 air, York Rd. Timonium, MD. 21093 Part I. Errer thy disease, of omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Thoracic AUVTIC Aneurs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to limit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to jor es a consequence of Examiner The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the pest 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 3 Probably 4 □Unknown 2 🗆 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 After this certificate filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 🗌 Yes Medical Certification: To 3□ DOA 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sott Atam Road MA 5 31. Date filed (Month, Day, Year) 32 egistrar's Signature State

Registrar
DHMH 17 Rev 1/2001

06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28486 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Year REGINA LANE SEPTEMBER 3, 2007 /Medical 21:45 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death JOHNS HOPKINS BATVIEW MEDICAL CENTER BALTINORE BALTIMORE CITY 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 🕏 F Days Hours Director 79 138-22-0914 April 16,1928 Maryland Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f she notified a Director 1 ☐Yes 21 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r 21222 7232 German Hill Road United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No à 3 Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William A. Bailey Anna Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) 611 Mr. Wilson A. Lane Riordan Terrace Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 9/6/2007 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hemorrhage Occult 16 hours /Medical Due to (or as a consequence of): Examiner Acides actic Sequentially list conditions, any teaching to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last hours Examiner Directo (or se a consequence of): that the death certificate be executed Hypotension
Duelo (or as a consequence of): hours and physician at s the burial-t Box 68760. Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy for in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 5 Other (specify) P.O. the 9□Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ arten disease history of myccordico Completed 1 ☐ Yes 2[**X**No 3 ☐ Probably 4 ☐Unknown interaction, congesting heart failure, alubetes mellitis 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?1 ☐ Yes 2 ☐ No Jas autopsy performed? Yes 2 No page hypercholesterolemia, hypertension certificate 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2) No 1X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attency within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only

Registrar

31. Date filed (Month, Day, Year) 0 6 2007

29b. Signature and title of cartifier

JOSE LUIS LOPEZ, MD, JOHNS HOPKINS BHYVEN MBDIKAL CENTER, 4940 Eastern Ave, BALTIMORE 32. Registrar's Signature

and manner stated

MD, Medical Doctor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c, License number

AF 2664200 - L474

29d. Date signed (Month, Day, Year)

MD 21224

9/3/07

07-06758 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Daisy Mae Lightner 2007 28487 1- For State Certificate of Death Registrar Physician/ 2. Date of Death . Decedent's Name (First, Middle,Last) Month Day August 27, 2007 Mae 0000 hrs Medical Examiner anther 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 2700 North Charles Street Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Funeral Foreign Months Davs Hours Director 219.40. Country) 06 М Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. Count NIA Baltimore MD 1 Yes 2 No 28a-f show Director 10e. Street and Numbe 10g. Citizen of What Country 21230 USA 1544 Sherwood Funeral 11. Mantal Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married Yes Black 3 X Widowed If Yes, Give Year Yes 2 No specify: Divorced Specify "natural" 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical Battimore, MD 21215-0036 permit. Pages I and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Domestic 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Sam Wester Many Be Gladden 19a. Informant's Name/Relation ip (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lightner Sherwood Avenue Balto. MD Daughter 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date other t crematory or other place) 1 Burial 2 Cremation Removal from State permit. Page:
Department or
Important: 1 Memorial Windsor Mill, MD 05 Donation 5 Other Specify 22. Name and Address of Facility Vaughn C. Greene Funeral Services nature of Funeral Service Licenses Itm ore MD 21212 Road **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and failure. List only one cause on each line /Medical Death Acute pneumonia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed Physician/Medical X UNPENDED the attending physician ed for use as the burial AMENDED, PII, 27, perME, g872, 10/30/07 TT To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760. IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown q Unknown Division of Vital Records, P.O. contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 Yes 2 No 3 Probably 4 V Unknown Hypertensive atherosclerotic cardiovascular disease: diabetes Completed has been 24a. Was an 24b. Were autopsy findings available mellitus; end stage renal disease autopsy prior to completion of cause of performed? death? certificate Yes 2 2 No ~ 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other 4 Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene this 7 1 ✓ Yes No After 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Yes 2 No 24 hours after death. Funeral Director: I Director: ed in by the f Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. September 1, 2007 Whila Grasiel 30. N me and ad ress of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 egistrar's Signati State 2007

DHMH 17 Rev 1/2001 OCME 2006

Registra

OCME

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month Year Leslie Κ. 28, /Medical August 2007 3:42 P 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Gilchrist Center Towson
If Under 1 Year | If Und <u>Baltimore</u> Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 X M 2 □ F Yrs. Director 350-20-9920 78 Nov 6, 1928 **Illinois** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2X No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 452 Five Farms Lane by Funeral 21093 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Radio & TV College (1-4or 5+) 12 04 Marketing Director Technology permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked othe any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Κ. Lear, Sr. Dorothy Ade1e Paoletti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy A. Lear/Wife 452 Five Farms Lane, Timonium, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 Removal from State Donation 5 ☐ Other (Specify) 9/1/07 Metro Crematory Catonsville, Maryland 22. Name and Address of Facility Bryan W. Clary Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 23a. Par 1. Enter t e disease, or complica ions that c. shr k, or heart failure. List only one ause on e sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ch line. Approximate Interval Between Onset and Death Immed ate Cause Final disease or condition resulting In) **Physician** UCMONARY BRUSL) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, physician Physician/Medical as attending p If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Wo Splee 1 ☐ Yes 2 🔀 No 2 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide **Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hospital or Attending Physician: n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral beath. completely the

20

State Registrar

Medical

(Check only

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES (M)

harles ST TOWSON

32. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 6 0

and manner stated.

			1 - For Amend Items Registrar	State of Ma 5 26,27 per	aryland / Depa r <b>dr.,g871</b> Cei	dment of H	eaith and Me <b>dhb</b> Death	ental Hygie	2007	28489
I	Physic	ian	Decedent's Name (First, Middle, La		1 - 11			2. Date of Death Month	Day Year	3. Time of Death
	/Medi Examir	cal	Eleanor  4a. Facility Name (If not institution, giv	a street and number)	LAH	16 City Town or	Location of Death	lugust 2	27 2007 4c. County of Deat	1640 ^M
	Exami	lei	Carroll Hospit		r	Westmins			Carroll	1
30	Funeral Director		200 03 0232	өх □м <b>2</b> ХО F 90	a (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birtl Co VA	nplace (State or Foreign untry)
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	ith the Marylar or 28a-f show	to	MD Carroll		Westmins	ster				1 □ Yes 2 □ No
	ith with the 23a or 28i	Il Direc	10e. Street and Number 3565 Cemetery Lar	ie		10f. Zip Code 21158		10g US	. Citizen of What Co	untry?
980	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show idical Examerational by rediffed at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give N Year or Dates:	lo	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 The	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ame Black, White Specify: whi	e, etc.
5-0	72 ho	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	tent's Usual Occupa kind of work done d	lurina most of workin	16	b. Kind of Business/I	ndustry
2121	ed within giene. er than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	life. I	OO NOT use retired)			ealth care	:
Maryland 21215-0036	i 2 should be filed within n and Mental Hygiene. 'is marked other than " raumatic event, the Men	To Be	17. Father's Name (First, Middle, Last) William Hottle				18. Mother's Name ( Mary Robi		iden Sumame)	
	Pages 1 an nent of Heal ant: If itam 2		19a. Informant's Name/Relationship ( Paul Lathe (son)	Type, Print)					ity or Town, State, Z MD 21158	, ,
Baltimore,			c. Location - City or Tandallstow							
Balti	permit. Pag Department Important: f any injury o		21. Signature of Funeral Service Licer  → Yugu Yuguy	see	Mt. Parar	. Name and Address		ht Funer	cal Home &	
	Trail		23a. Part1. Enter the disease, or companies shock, or heart failure. List only	plications that caused	the death. Do not ente					Approximate Interval Between
H	Physician		Immediate Cause (Final disease or condition resulting in death)	a Card	Go pul-	nonary	Arre	st		Onset and Death
	/Medical Examiner		- cooding in accumy	Due to (or as a	consequence of):	to she	20515			
	p tis	iner	Sequentially list conditions, I any, Leading to instructions cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence or):	112 370	710313			
	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
68760,	ificate be executed g physician and as the burial-transit	edical E		d						
	eath certific attending pl		IF FEMALE:	23c. If yes, outcome o	of pregnancy					
.O. Box	requires that the death cert een signed by the attendin nould be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Who 9 Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 ☐Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of deliv	Day Year
Δ.	uires that signed b Id be deta	by	Part II. Other significant conditions of	ontributing to death but	t not resulting in the un	derlying cause giver	n in Part I.		co use contribute to 2 DNo 3 □ Pro	the cause of death?
SCOL	law require as been sig 2 should b	ompleted						24a. Was an		opsy findings available
of Vital Records,	The ate his page	Сош						autopsy performed 1 ☐ Yes 2 ☑	prior to co death? No 1 ☐ Yes	opsy findings available ompletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othor	26. Place of Death			
of	g Phys er this eral di	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury		3 DOA Other	4 Inuising Home	5 Residence d. Describe how i	e 6 Other (Speci	(fy)
sion	Attanding r death. ector: After by the funer	atlo	1 Natural 5 Pending investigation	(Month, Day	Year) Injury		? es 2□No			
Division	al or Att s after de n Direct ad in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	et, factory, office	28	f. Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,
	To the Hospital or Attanding Ph within 24 hours after death. To tha Funaral Director: After th completely filled in by the funeral	edical (	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of iner: On the basis of e and manner state	my knowledge, death examination and/or invested.	occurred at the time estigation, in my opin	e, date and place, an nion, death occurred	d due to the caus at the time, date	e(s) and manner as and place, and due t	stated. o the cause(s)
ı	To the within 2 To tha complet	Me	29b. Signature and title of certifier	10-	- MI	29c. License			Date signed (Month,	
/	(Z)		Tat ha	- Nag	)		061755	8	3/28/20	00 +
(	9		30. Name and address of person who of Lather Nagana	ompleted cause of dea	ath (Item 23a) (Type, F	Print) OLF RD	WEST	UNSTEA	, MD 2	1157
	Sta Registra	- 4	31. Date filed (Month, Day Y) ar) SEP 0 6 2	32 Hegistrar	700 A PO	calls				

Physicia /Medic		State Registrar		Certificate of Death	nd Mental Hygie Reg	<u>.,2007 28</u>	4 57
	al	1. Decedent's Name (First, Middle, Last)	Miller		2. Date of Death Month	Day Year 3. Tim	e of Death
Examin Funeral	er	4a. Facility Name (If not institution, give s  5. Nocial Security Number 6. Sex	tal		Hrs. I B. Date of Birth	4c. County of Death  PA  9. Birthplace (Sta	te or Foreic
Director		Usual Residence of Decedent		Yrs.	Min. Sept 4	1732 n. CAroli	nci
ati with the majation 1238 or 288-f show	Director	10a. State 10b. County	10c. City, Town	al himin			e City Limit
ms 23e or 28a		10e. Street and Number 2613 SHIMEY H	lve	10f. Zip Code	10g	Citizen of What Country?	
	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 3 M6 If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No- querto Rican, etc.)	14. Race - American Indian Black, White, etc.  Specify: Black	1,
ene. than "natural',	Completed	(Specify only highest grade	College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working	b. Kind of Business/Industry	66-
if of Health and Mental Hygiene.  If item 27 is marked other than "natural", or item or other traumatic event, If a Musical Examination.	To Be Co	17 Eather's Name (First, Middle, Last)  BLUTUS CHAMBE		A .	Name (First, Middle, Ma.	iden Sumame)	9 6,
of Health and N item 27 is ma r other trauma		19a. Informant's Name/Relationship (Typ. Kenneth Cham)	BERT /SON 36	Mailing Address (Street and Number of	o Bolhow	E My 212	
ant ury		20a. Method of Disposition  ■ Surial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)  21. Signature of Fungial Service License	emoval from State  Cemeter  At In	Disposition (Name of y, crematory or other place)  Cricky,  22. Name and Ad ress of Facility	8/07 200	Lansdowne, Md	-
nysician Medical	-	23a. Part Ener the dise se, or complication or heart failur. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not be cause on each line.	Obstrudive,		Interval	nate Between nd Death
	dicai Examiner	Sequentially list conditions, cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of				
e attending id for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ② No 9 ☐ Unknown	Bc. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day	Year
gned b	þ	Part II. Other significant conditions cont	tributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of 2 No 3 Probably 4	of death?
an si	4						
ate has been s page 2 should	Completed				24a. Was an autopsy performed		□Unknow
this certificate has been s al director, page 2 should	To Be	27. Manno of Death	ospital: 1 Inpatient 2 IL R/Out	patient 3 DOA Other: 4 Nursir	<ul><li>autopsy performed</li></ul>	Prior to completion of death? No 1 □ Yes 2 □ No  e 6 □ Other (Specify)	□Unknow
death. ctor: Affer this certifice y the funeral director, p	To Be	examiner?	28a. Date of Injury 28b. T	patient 3 DOA Other: 4 Nursin lime of lighty M 28c. Injury at Work?  M 1 Yes 2 No	autopsy performer, 1   Yes 2   Death   Check only one)  In the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con	prior to completion of death?  No 1 Yes 2 No  1 Yes 2 No  1 Other (Specify)  Injury occurred	Unknow gs availab f cause of
irs after death. ral Director: After this certifica led in by the funeral director, p	To Be	examiner?  1	28a. Date of Injury (Month, Day Year)  28b. Place of Injury - At home, far building, etc. (Specify)	patient 3 DOA Other: 4 Nursin lime of lighty M 28c. Injury at Work?  M 1 Yes 2 No	autopsy performer, 1 Yes 2 Death (Check only one)  19 Home 5 Residence 28d. Describe how in the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the	prior to completion of death?  No 1 Yes 2 No  a 6 Other (Specify)  njury occurred  t and Number or Rural Route Notate)	Unknowr gs available i cause of cause of

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ORIGINAL

			For State Registrar	State of Ma	iryland /	Depa Cer	artment of Hartificate of L	ealth and M Death	lental Hygi Rei	ene 200	7 28491
	Physici		1. Decedent's Name (First, Middle, La Elizabeth	ast)			ock		2. Date of Death Month 8 31	Day Ye	ear 3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)			4b. City, Town, or	Location of Death		4c. County of	
			150 W. Hamburg	Street 1s	t Floor	<u>-</u>	Bal	timore		NA	NA
(A)	Funeral			Sex 7. Age 1 ☐ M 2 K F	(In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Director		219-26-7741 Usual Residence of Decedent	- 75	69	115.			4-27-19		Md.
	yland yland at		10a. State 10b. County		10c. City, Tow	vn or Lo	cation				10d. Inside City Limits
	a-f sh	ctor	Md. NA		Ba	lti	more				1 X Yes 2 □ No
	ith the	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of Wha	it Country?
	ath w	<u>ra</u>	150 W. Hamburg		Floor		21230			USA	
	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
36	ırs afı al",or xami	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	O		1 ☐ Yes 2 No	Specify:		Specify:	3lack
ş			15. Decedent's E (Specify only highest gr	ducation	16a	. Deced	ient's Usual Occupa	ition	10	l 6b. Kind of Busin	ess/Industry
7	within 72 ene. than "na he Medic	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	+)	life. i	kind of work done d OO NOT use retired)	uring most of worki	ng		
7	filed wi Hygier other the		12th grade	NA		Sel	f-Employe				e Provider
and		Be	17. Father's Name (First, Middle, Las  Martin	t) Lee	Molock			18. Mother's Name Edith	e (First, Middle, Ma		~
$\leq$	2 should and Men Is marke	2	19a. Informant's Name/Relationship				g Address (Street a		al Pauta Number	Davis	
Mar	and 2 s ealth ar n 27 ls er trau		Kenneth Molock	Son	10.		04 Souther				21206
ē,	- 프 호 형		20a. Method of Disposition		20b. Place o	of Dispo	sition (Name of natory or other place	i		Oc. Location - City	
Ē	Pages nent of int: If its iry or o		1  Burial 2  Cremation 3 4  Donation 5  Other (Speci		1 .		m. Park	· i	7-07	Randalls	stown, Md.
Baltimore,	permit. Pages Department of Important: If It any injury or of		21. Signature of Funeral Service Lice	nsee	)	22	Name and Address	s of Facility Ma North Ave			
		_	23a. Part1. Enter the disease, or con	nolications that caused	the death. Do	not ent					Approximate
	Dhysisian		Immediate Cause (Final	one cause on each line	0 20	6				ι,	Interval Between Onset and Death
k.	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a	consequen	off:	Rent	auen	Z		years
	Examiner			h		0.7.					
	D ==	ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	of):					3
	ificate be executed physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
Ď,	be exician a			Due to (or as a	consequence	ot):					
09/90	ficate physics the	edical		<b>_</b> d			<u> </u>				
XOD	nding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p						23d. Date of	f delivery
ŏ	d for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 4□Pregnant at t			Ectopic pregnancy Other (specify)			Month	,
5	t the by the tache	hys	9 Unknown	9□Unknown							
'n	es the gned se de	by P	Part II. Other significant conditions	0 n n	11 10	n the ur	iderlying cause giver	n in Part I.	23e. Did toba	cco use contribu	te to the cause of death?
ecoras,	requir		CKNOW ON	wit Jil	rilled		****		1 Tes	2 <b>X</b> No 3[	☐ Probably 4 ☐ Unknown
<u> </u>	law nas be e 2 sh	Completed						· · · · · · · · · · · · · · · · · · ·	24a. Was an autopsy	prio	re autopsy findings available r to completion of cause of
<u></u>	n: The icate r, pag	ပ်							performe 1∐ Yes 2[		th? Yes 2□ No
N I G	siciar certif rector	Be	25. Was case referred to medical examiner?	Hospital:			Other	26. Place of Death	10		
5	Physer this eral di	<u>۽</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury		itpatien Time of	28c. Injury	at Nursing Hor	me 5 Residen		Specify)
VISION	nding tth. r; Affe e fune	ğ	1 Natural 5 ☐ Pending investigatio	(Month, Day n	Year)	Injury	Work? M 1 □ Y	? es 2 □ No		.,.,	
2	ar dea recto	Ę	3 ☐ Suicide 6 ☐ Could not be determined			ırm, stre	eet, factory, office	2	28f. Location (Stre City or Town,	et and Number o	or Rural Route Number,
2	ital or rs afte al Dil	Certification:		Danaing, etc.	(00000)				Oity of Town,	State/	
		Medical	29a. Certifier 1 CertifyIng Pl (Check only one) 2 Medical Exa	nysician: To the best of miner: On the basis of e	examination ar	e, death nd/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurr	and due to the cau red at the time, dat	se(s) and manne e and place, and	er as stated. due to the cause(s)
	o the	Mec	29b. Signature and tipe of certifier	and manner state	eu.		29c. License	number	. 29d	I. Date signed ///	fonth, Day, Year)
)	FSF6		VI-Alex	/ Kin			a	1816	/   ,	lost 1	4 2007
6	5 Y		30. Name and address of person who,	completed cause of dea	ath (Item 23a)	(Type, i	21.0	(			
Ó			Chi-Shing C	ney. My	31	10	ST. Yau	1 Place	Ste Yua	Balto,	MO 21202
	Star Registra	e ar	31. Date filed (Month, Day, Year) SEP 0 6 2007	32. Registrar	's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 10:45a^M **Physician** 9 Muse 2007 Dorothy /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NA Baltimore Future Care-Canton Harbor If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days **Funeral** 1 □ M 2 □ F 80 Va. 7-3-1927 218-22-6887 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Baltimore NA Md. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21213 by Funeral 2021 E. Chase Street 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: Baltimore, Maryland 21215-0036 Black 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 Is marked other than "I r traumatic event, the Med College (1-4or 5+) Elementary/Secondary (0-12) Virginia Bakery Baker 7th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe Clara Johnson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Important: If them 27 Is any injury or other traum 2021 E. Chase Street, Baltimore, Md. James Muse 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-7-07 Baltimore, Md. Greenmount Cem. 22. Name and Address of Facility March F.H. East 21. Signature of Funeral Service Licensee 21202 1101 E. North Ave., Baltimore, Md. B la war 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CAnce Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 1☐Live birth 3 ☐ Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death s been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 | Yes 2 | No 3 | Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy performed? 2 No 1 🗆 Yes certificate 26. Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be Other: Hospital: 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) filted in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined 4 🗌 Homicide within 24 hours af

To the Funeral D

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Hospital 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) venue Balti BOB 2835 MO

State Registrar

31. Date filed (Month, Day, Year)

6 2007

DHMH 17 Rev 1/2001

. Registrar's Signature

Physician /Medical Examiner attending physician the Hospital or Attending Physician:

Examine Physician/Medical Completed by Be Certification: To

cal

**Physician** 

/Medical

Examiner

**Funeral** 

Director

an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at

than "

permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien. Important: if item 27 is marked other the any injury or other traumatic event, the in one.

Director

Funeral

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Completed

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

7

29c. License number

Towson MD

29d. Date signed (Month, Day, Year)

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State Registrar

32. Regimar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

407

Load #301

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After this

Director:

e Funeral

within 2. To the I

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

York

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death September **Physician** onia, 2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner University of Maryland Medical Center
5. Social Security Number 6. Sex , 7. And (In use has been 4b. City, Town, or Location of Death 4c. County of Death Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 D Min. Days Hours 35.7688 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at anone. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director a17011 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 29040 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married ☐ Yes 2 No f Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 Yes 2 No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Puerto hican Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) House Wi Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Modriquez Martinez luana 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thosado hentford Moad Owings mills mo William 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State Evergreen 22. Name and Address of Facility Voughn C. Greene funeral Service 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8728 Liberty Moad Thondallstan mo Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Endometrial Carcinoma disease or conditior resulting in death) 6 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 TYes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? death? certificate 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ٩ 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated.

To the

Division or Vital Records, P.O. Box 68760,

Zan Zaidi, M.D 31. Date filed (Month, Day, Year) SEP 06

30. Name and address of pe

and title of certifi

2007

29b. Signate

22 S. Greene St., Baltimore MD 21201 32. gistrar's Signature

on who completed cause of death (Item 23a) (Type, Print)

State

Registrar

29c. License number

1376747212

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black indelible Ink. Ensure All Copies Are Legible. State of Maryland Por Physion 687 Health And Wental Hygiene Certificate of Death Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death John David McRae Month **Physician** 2010 PM 7007 /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wien timore 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Sex 1**X**M 2□F Months Days Hours Min **Director** Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore 1 ☐ es 2 ☐ No MD 10e. Street and Number 10g. Citizen of What Country? 21206 USA Funeral Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 3/ack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DQ NQT use retired) College (1-4or 5+) eligion d 2 should be filed with and Mental Hygier 7 Is marked other the 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; if item 27 Is any injury or other trauonce. 5909 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee M01363 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. sequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Mellitus be executed P.O. Box 68760, attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the a detached i 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to peath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Strige greate None 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy performed? (es 2) No certificate 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl o e) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 3DOA 2 ER/Outpatient 1 🗌 Inpatient this After thi funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural (Month, Day Year) 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

Aun tetkoutt, N.S. 29c. License number 037-70 29d. Date signed (Month, Day, Year) 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rondallstown, Md. 21133 surte 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 06 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State amend item 23a-d, 25 per ME g8773/20/08 amb
Registrar

Registrar

Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 **Physician** MCCONNELL JAMES 21:37M September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL BALTIMURE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 XM 2 ☐ F Director 268-14-0419 May 27, 1919 88 Ohio Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 217 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 760 Winterfield Court 21015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ★Yes 2 □ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Maritai Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ò Specify. Specify: 3 ₩idowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Air Conditioning Elementary/Secondary (0-12) College (1-4or 5+) Manufacturer 12 should be filed wind mand Mental Hygier Executive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Paul (nmn) McConnell Grace (nmn) Arting 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a James R. McConnell Jr. Son 19515 Spring Valley Drive, Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Itel any Injury or otl 1 Burial 2 □ Cremation 3 Permoval from State 4 ☐ Donation 5 ☐ Other (Specify) Mansfield Cemetery 9-8-07 Mansfield, Ohio 21. Signature of Funeral Service Licensee McComas fune Faity Home, P.A. Slig (ass 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HYPOXIA day5 /Medical Due to (or as a consequence of): Examiner concestive CERTIFICATION APPROVED BY MEDICAL EXAMINER Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Intarction certificate be executed Myocardial and burial-tran Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the IF FEMALE use a 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) P.O. the a 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Couradin Thrombosis 1 Yes 2 No 3 Probably 4 \undachdred Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has le 2 autopsy page, perform certificate 2 X No Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 5 Pending investigation within 24 hours area control to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ö 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES - 000 September 05, 2007 600 N Write Street 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BethHore Mary land 21287 Bueso Medicine Doctor Johns Hopkins Itospital MONICE

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 6 2007

marke.

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 28497 Certificate of Death Reg No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Month Day Marie Barbara Massimini 10:05AM 2007 SFP 9 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST AGNES CARG HEALTH RALTIMORE 8. Date of Birth (Month, Day, Year)
Dec. 16, 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1□M 2ĀF Months Days Hours Maryland 213-12-6918 86 **1**920 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show at 28a-f sh notified 1 ☐ Yes 2X No Funeral Director MD Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 1241 Birch Avenue 21227 ms 23a United States Was Decedent of Hispanic Origin? (Specify Yes or Noif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ANo "natural", or items 14. Race - American Indian, 11 Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 Yes 2 No Specify: <u>≽</u> Specify: White Widowed 4 □ Divorced Be Completed th and Mental Hygiene.

7 is marked other than "natur traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County Cafeteria Worker Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Bachmann ပ Anna Marie Schmedes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trai Kenny Massimini - Son 1800 Clark Blvd., Baltimore, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MD veterans Cemetery 9-6-2007 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD @ Crownsville 22. Name and Address of Facility Am rose Funeral Home, Inc. 21. Signature of Funeral Service Licensee repen. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASPIRATION PNEUMONIA /Medical Due to (or as a consequence of): Examiner HIP PROSTHESI 15 DAYC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trai Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, RHEUMATOID ARTHRITIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy 1☐ Yes or Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Math 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred The Hospital or At.

Thours after death.

I Director: After by the fur Certification: Division 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral D completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P19923 Suvaechala MO SEP, 2, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Suvalchala Kompella, ST-ACNES HEALTH CARE Suvaechala Kompella, 1 MD, 21929. 31. Date filed (Month, Day, Year) 32. gratrar's Signature SEP 06 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Aurelio Gonzalez Martinez September 4, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mallard Bay Nursing Home Cambridge Dorchester If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 5. Social Security Number 6. Sex 1X M 2 ☐ F 8. Date of Birth (Month, Day, Year)

Jan. 13, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Director 057-12-6818 86 1921 Florida Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 ☐ Yes 2 X No Director Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Exa⊓iner must be 1008 Glasgow Street 21613 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2□ No 1944-If Yes, Give Year or Dates: 1945 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 □ No Specify: Cuban ģ Specify: White 3 Widowed 4 □ Divorced 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chef Pages 1 and 2 should be filed w treent of Health and Mental Hygien rtant: If item 27 is marked other th lury or other traumatic event, th Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucas Martinez Celia Gonzalez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 Is any injury or other trau 1008 Glasgow Street, Cambridge MD 21613
e of Disposition (Name of Date 200. Location - City or Town, State Bruce Martinez - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 □ Cremation 3 □ Remo I from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 9-8-2007 Brooklyn, MD Signa ure of Funeral Signature License 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Ferry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. Libronly one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer **Physician** -010h /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) l in by 1 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar

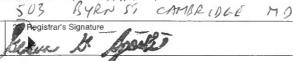
31. Date filed (Month, Day, Year) SEP 06

THANWY

30. Name and address of person who completed wuse of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

NOMAN



29d. Date signed (Month, Day, Year) 9.5-07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28499 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date Month 2. Date of Death 3. Time of Death Day Year 15To INSKINS 11:15AM 31 200.7 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 67 Months Days Min 1**X** M 2□ F CA. 216-36-9074 9-21-1939 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No MD. BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1744 CHESACO AVE. 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes ŽŽNo Specify: WHITE Specify. 3 ☐ Widowed 4X Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) UNK. BARTENDER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JERRY MOSKIOS MARY (WOLF) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANINE RATCLIFF (DAUGHTER) 4530 FITCH AVE. BALTO. MD. 21236 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State PARKWOOD CEMETERY 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 9-4-2007BALIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE. ROSEDALE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SCUEROSIS 994 Due to (or as a consequence of): 2000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? NONTINGRE P No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, 1 Yes 2 Mo Hospital:

permit. Pages 1 and 2 should be filled.
Department of Health and Mental Pulmportant: If Item 27 is many injury or other. **Physician** /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be ပ

**Funeral** 

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

e filed within 72 hours after all Hygiene.

3altimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

death 1

attending physician and for use as the burial-transit peen has page 2

law requires that the death certificate be executed signed by the al certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

Physician/Medical <u>م</u> Completed 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 4 ☐ Homicide

29a, Certifier

31. Date filed (Month, Day,

Be

P

Certification:

Medical

State Registrar

Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 ☐ Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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30-Name and address of person who co eath (Item 23a) (Type, Print) M

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19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21237 20c. Location - City or Town, State 9-6-2007 BALTIMORE, MD. 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive, Baltimore MD, 21237

Year

2007

να,

10d. Inside City Limits

1 ☐ Yes 2 No

3 State Registrar 29b. Signature and title of pertifier

31. Date filed (Month, Day, Year)

Abus Year)

0 6 2007

Se. Registrar's Signature